

**State:** Arkansas **Filing Company:** Thrivent Financial for Lutherans  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.004 Partnership  
**Product Name:** Long-Term Care (2012)  
**Project Name/Number:** /

## Filing at a Glance

Company: Thrivent Financial for Lutherans  
Product Name: Long-Term Care (2012)  
State: Arkansas  
TOI: LTC03I Individual Long Term Care  
Sub-TOI: LTC03I.004 Partnership  
Filing Type: Form/Rate  
Date Submitted: 08/07/2012  
SERFF Tr Num: THRV-128572645  
SERFF Status: Closed-Approved  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num:  
  
Implementation  
Date Requested:  
Author(s): Karen Guyette, Matt Holderness, Jane Larson  
Reviewer(s): Donna Lambert (primary)  
Disposition Date: 09/21/2012  
Disposition Status: Approved  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Thrivent Financial for Lutherans  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.004 Partnership  
**Product Name:** Long-Term Care (2012)  
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## General Information

Project Name: Status of Filing in Domicile:  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 09/21/2012  
State Status Changed: 09/21/2012  
Deemer Date: Created By: Karen Guyette  
Submitted By: Karen Guyette Corresponding Filing Tracking Number:

### Filing Description:

We are submitting for your review and approval a long-term care insurance contract, eleven riders, five applications, and an application change form. Each of these new forms is described below.

#### Form H-HL-LTC (12), Long-Term Care Insurance Contract

This is a guaranteed renewable qualified long-term care insurance contract with benefits for residential facility, home and community-based care. This contract includes ancillary benefits for respite care, equipment/home modification, caregiver training, and international care. Coverage is provided in the form of reimbursement for expenses incurred for qualified long-term care services when eligibility for benefits is met. Payment is subject to the elimination period, maximum monthly benefit, available benefit, ancillary benefit limits, exceptions and limitations, and all other terms and conditions of the contract.

#### Form HR-HC-CB (12), Cash Benefit Rider

In any calendar month in which the Insured receives Long-Term Care Benefits for expenses incurred on at least five separate days and the Elimination Period has ended, this rider pays a benefit equal to: 1) 15% of the Maximum Monthly Benefit in effect on the last day of the calendar month if on any of those days the Insured received Adult Day Care or Home Health Care Benefits; otherwise 2) 10% of the Maximum Monthly Benefit in effect on the last day of the calendar month. This form will be made a part of the contract at issue if elected by the proposed insured. It can also be added after the date of issue of a contract.

#### Form HR-HT-CAIB3 (12), Compound 3% Annual Increase Benefit Rider

This rider increases the Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by 3% of the corresponding amounts in effect immediately before the increase. Premiums for this rider are set at the time of issue. Increases in coverage under this rider will not cause an increase in the contract's premium. This form will be made a part of the contract at issue if elected by the proposed insured. It can also be added to the contract after the date of issue of that contract.

#### Form HR-HV-CAIB5 (12), Compound 5% Annual Increase Benefit Rider

This rider increases the Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by 5% of the corresponding amounts in effect immediately before the increase. Premiums for this rider are set at the time of issue. Increases in coverage under this rider will not cause an increase in the contract's premium. This form will be made a part of the contract at issue if elected by the proposed insured. It can also be added to the contract after the date of issue of that contract.

#### Form HR-HF-FIB (12), Flexible Increase Benefit Rider

This rider increases the Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by

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5% of the corresponding amounts in effect immediately before the increase. The insured may decline the increase. If the insured declines three consecutive increases, automatic annual increases will cease and future increases will be provided only on rider anniversaries occurring while premiums are being waived under the Waiver of Premium provision of the contract. Premiums for this rider are set at the time of issue. The contract's premium will increase with each option elected and will be based on the insured's age at the time of the increase. This form will be made a part of the contract at issue if elected by the proposed insured. It can also be added to the contract after the date of issue of that contract.

Form HR-HL-LCNF (12), Limited Premium Payment Period Contingent Nonforfeiture Benefit Rider

If the Limited Premium Payment Period Contingent Nonforfeiture Benefit is triggered, this rider provides paid-up coverage with reduced benefit maximums if the insured gives notice to cancel the contract or the contract terminates for nonpayment of premium. The Available Benefit, Maximum Monthly Benefit and Ancillary Benefit Limits will be reduced to amounts equal to 90% of the amounts in effect immediately before the date paid-up coverage becomes effective, multiplied by the ratio of the number of months that premiums were paid, divided by the number of months in the premium paying period. There is no charge for this rider and it is automatically included as part of a contract that has a limited premium payment period. It cannot be added to the contract after the date of issue of that contract.

Form HR-HN-NF (12), Nonforfeiture Benefit Rider

After the contract has been in force for three years, this rider provides paid-up coverage if the insured gives notice to cancel the contract or the contract terminates for nonpayment of premium.

The paid-up coverage will have an Available Benefit equal to the lesser of the Nonforfeiture Credit and the Available Benefit in effect immediately before the date paid-up coverage becomes effective. The Nonforfeiture Credit is equal to the greater of the total of all premiums paid for the contract and the Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective. This form will be made a part of the contract at issue if elected by the proposed insured. It cannot be added to the contract after the date of issue of that contract.

Form HR-HR-RB (12), Restoration of Benefits Rider

This rider restores the Available Benefit and amounts available for Ancillary Benefits if, after receiving benefits, the insured has not been Chronically Ill for a period of 180 consecutive days and the contract is still in force at the end of that period. The Available Benefit will be restored to the amount that would have been in effect had no benefits been paid. Amounts paid for Ancillary Long-Term Care Benefits prior to the day after the 180-day period will be disregarded when calculating new amounts payable for Ancillary Long-Term Care Benefits. There is no limit on how often benefits paid under the contract can be restored. This form will be made a part of the contract at issue if elected by the proposed insured. It can also be added to the contract after the date of issue of that contract.

Form HR-HP-RP (12), Return of Premium upon Death Rider

This rider will return premiums paid (less any benefits paid and accumulated dividends paid upon death) to the insured's estate if the insured dies and this rider has been in force for at least ten years. This form will be made a part of the contract at issue if elected by the proposed insured. It cannot be added to the contract after the date of issue of that contract.

Form HR-HS-SC (12), Shared Care Benefit Rider

This rider allows the insured and the insured's benefit partner to share each other's Available Benefit if one of them exhausts his or her own Available Benefit. The insured and the insured's benefit partner must each own a Thrivent Financial for Lutherans long-term care insurance contract with identical coverage that includes this rider and names each other as a benefit partner. This form will be made a part of the contract at issue if elected by the proposed insured. It cannot be added to the contract after the date of issue of that contract.

Form HR-HU-SU (12), Survivorship Benefit Rider

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This rider will waive premiums for life if after ten years from the date of issue of the rider the insured's benefit partner dies. This benefit will not be paid if either the insured or the insured's benefit partner were Chronically Ill within the first ten years from the date of issue of the contract. The insured and the insured's benefit partner must each own a Thrivent Financial for Lutherans long-term care insurance contract with the same date of issue that includes this rider and names each other as a benefit partner. This form will be made a part of the contract at issue if elected by the proposed insured. It cannot be added to the contract after the date of issue of that contract.

**Form HR-HE-WEP (12), Waiver of Elimination Period for Home Care and Adult Day Care Rider**

This rider will waive the Elimination Period requirement when receiving benefits for Home Care or Adult Day Care. The days of care the insured receives will still help to satisfy the Elimination Period for other types of care that may be needed in the future. This form will be made a part of the contract at issue if elected by the proposed insured. It can also be added to the contract after the date of issue of that contract.

**Form 27154 N1-12, Application for Individual Long-Term Care Insurance**

This application will be used to apply for the Long-Term Care Insurance Contract and optional riders. This application will also be used to request changes to existing contracts.

**Form 27253 N1-12, Preliminary Declaration of Insurability Long-Term Care Insurance**

This application will be used with application form 27154 N1-12 when evidence of insurability is required for the proposed insured.

**Form 27158 N1-12, Declaration of Insurability Long-Term Care Insurance**

This application will be used with application form 27154 N1-12 when evidence of insurability is required for the proposed insured.

**Form 27159 N1-12, Supplement to Declaration of Insurability Long-Term Care Insurance**

This application will be used with application form 27158 N1-12 when additional space is needed for entering information in response to question 15 concerning aid, appliance or assistance details.

**Form 27507 N1-12, Residual Benefit Declaration of Insurability for Individual Long-Term Care Insurance**

This application will be used to apply for the Residual Benefit on a contract with the Shared Care Benefit Rider when an insured's Available Benefit has been reduced to \$0 solely due to payment of benefits for their Benefit Partner.

**Form 20887A N1-12, Application Change**

This is a new application form that will be used to verify, change or correct information contained in application forms 27154 N1-12, 27253 N1-12, and 27158 N1-12.

**Applications**

These applications may be completed electronically on a laptop computer or manually on a paper copy. The application software on each representative's computer is secure and cannot be altered by the agent. Applications completed on the computer may be electronically submitted to our home office or they may be printed, signed and mailed to us. When a computer application is completed and has been reviewed by the applicant, all necessary signatures are captured electronically and transmitted as part of the application. Signatures are encrypted and cannot be transferred or used for any other purpose. If any changes are made to the application after the signature has been processed, the signature will be erased and the entire application must then be reviewed and signed again. In all cases, a printed copy of the signed application will be included in the contract at time of issue.

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#### Forms Filed for Information

The following forms are being filed for information and are attached under Supporting Documentation:

- 1) Form 27160 N1-12, Long-Term Care Insurance Outline of Coverage
- 2) Form 27156 N1-12, Long-Term Care Insurance Personal Worksheet

#### Other Forms

The following previously approved forms which were approved by your Department on 2/05/2003 will be used with the Declaration of Insurability Long-Term Care Insurance, form 27158 N1-12:

- 1) Supplement to Application for Insurance, Form 21027 N1-03
- 2) Supplement to Application for Insurance, Form 21030 N1-03
- 3) Supplement to Application for Insurance, Form 21031 N1-03
- 4) Supplement to Application for Insurance, Form 23029 N1-03

The following previously approved form which was approved by your Department on 8/09/2010 will be used with the contract:

- 1) Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance, Form 26786 N9-10.

#### Changes in Format

The forms submitted for review and approval are in final printed form. Minor modifications could occur in format, such as word wrap, pagination or balancing text on a page. However, the wording of the forms will not be changed.

#### Long Term Care Partnership Program Certification

A completed Long Term Care Partnership Certification Form is included in this filing. Please note that whether or not the policy issued is a Partnership policy will be determined by the individual's age and the inflation protection he or she elects. If the inflation protection elected complies with your state's Partnership requirements for that individual's age band, the policy will be a Partnership policy; otherwise, the policy will be a non-Partnership policy.

#### Marketing

This contract and riders will be offered by Thrivent Financial for Lutherans representatives to Lutheran individuals (issue ages 18-79) in the following rate classes: Preferred, Standard, Substandard 1, and Substandard 2

#### Advertising Material

The advertising material will be filed after the contract is approved.

## Company and Contact

### Filing Contact Information

Karen Guyette, Compliance Specialist II karen.guyette@Thrivent.com  
625 Fourth Ave. South 800-847-4836 [Phone] 37251 [Ext]  
Minneapolis, MN 55415 612-340-5040 [FAX]

### Filing Company Information

Thrivent Financial for Lutherans	CoCode: 56014	State of Domicile: Wisconsin
4321 North Ballard Road	Group Code: 2938	Company Type: Fraternal
Appleton, WI 54919-0001	Group Name:	State ID Number:
(800) 847-4836 ext. [Phone]	FEIN Number: 39-0123480	

**State:** Arkansas **Filing Company:** Thrivent Financial for Lutherans  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$900.00  
 Retaliatory? No  
 Fee Explanation: 18 forms x \$50 = \$900  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Thrivent Financial for Lutherans	\$900.00	08/07/2012	61475623

SERFF Tracking #:

THR-128572645

State Tracking #:

Company Tracking #:

State: Arkansas  
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 Product Name: Long-Term Care (2012)  
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Filing Company: Thrivent Financial for Lutherans

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	09/21/2012	09/21/2012
Approved	Donna Lambert	08/15/2012	08/15/2012

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	08/13/2012	08/13/2012

#### Response Letters

Responded By	Created On	Date Submitted
Karen Guyette	08/15/2012	08/15/2012

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Individual Long-Term Care Insurance	Karen Guyette	09/20/2012	09/20/2012
Supporting Document	Statement of Variability	Karen Guyette	09/20/2012	09/20/2012
Rate	Rate Schedules	Karen Guyette	08/08/2012	08/08/2012
Supporting Document	Health - Actuarial Justification	Karen Guyette	08/08/2012	08/08/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Reopen Filing	Note To Filer	Donna Lambert	09/20/2012	09/20/2012
Request to Re-Open Filing	Note To Reviewer	Karen Guyette	09/20/2012	09/20/2012

SERFF Tracking #:

THRV-128572645

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name:

Long-Term Care (2012)

Project Name/Number:

/

## Disposition

Disposition Date: 09/21/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Thrivent Financial for Lutherans	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

THRV-128572645

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name: Long-Term Care (2012)

Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Long-Term Care Insurance Personal Worksheet	Approved	Yes
Supporting Document (revised)	Statement of Variability	Approved	Yes
Supporting Document	Statement of Variability	Replaced	Yes
Supporting Document	Issuer Certification Form for Qualified Partnership Policies	Approved	Yes
Form (revised)	Long-Term Care Insurance Contract	Approved	Yes
Form	Long-Term Care Insurance Contract	Replaced	Yes
Form	Cash Benefit Rider	Approved	Yes
Form	Compound 3% Annual Increase Benefit Rider	Approved	Yes
Form	Compound 5% Annual Increase Benefit Rider	Approved	Yes
Form	Flexible Increase Benefit Rider	Approved	Yes
Form	Limited Premium Payment Period Contingent Nonforfeiture Benefit Rider	Approved	Yes
Form	Nonforfeiture Benefit Rider	Approved	Yes
Form	Restoration of Benefits Rider	Approved	Yes
Form	Return of Premium Upon Death Rider	Approved	Yes
Form	Shared Care Benefit Rider	Approved	Yes
Form	Survivorship Benefit Rider	Approved	Yes

**SERFF Tracking #:**

THR-128572645

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Thrivent Financial for Lutherans

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.004 Partnership

**Product Name:**

Long-Term Care (2012)

**Project Name/Number:**

/

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Form</b>	Waiver of Elimination Period for Home Care and Adult Day Care Rider	Approved	Yes
<b>Form (revised)</b>	Application for Individual Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Application for Individual Long-Term Care Insurance	Replaced	Yes
<b>Form</b>	Preliminary Declaration of Insurability Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Declaration of Insurability Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Supplement to Declaration of Insurability Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Residual Benefit Declaration of Insurability for Individual Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Application Change	Approved	Yes
<b>Rate (revised)</b>	Rate Schedules	Approved	Yes
<b>Rate</b>	Rate Schedules	Replaced	Yes

**SERFF Tracking #:**

THR-128572645

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Thrivent Financial for Lutherans

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.004 Partnership

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## Disposition

Disposition Date: 08/15/2012

Implementation Date:

Status: Approved

Comment:

<b>Company Name:</b>	<b>Overall % Indicated Change:</b>	<b>Overall % Rate Impact:</b>	<b>Written Premium Change for this Program:</b>	<b># of Policy Holders Affected for this Program:</b>	<b>Written Premium for this Program:</b>	<b>Maximum % Change (where req'd):</b>	<b>Minimum % Change (where req'd):</b>
Thrivent Financial for Lutherans	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

THR-128572645

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Thrivent Financial for Lutherans

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Product Name: Long-Term Care (2012)

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Long-Term Care Insurance Personal Worksheet	Approved	Yes
Supporting Document (revised)	Statement of Variability	Approved	Yes
Supporting Document	Statement of Variability	Replaced	Yes
Supporting Document	Issuer Certification Form for Qualified Partnership Policies	Approved	Yes
Form (revised)	Long-Term Care Insurance Contract	Approved	Yes
Form	Long-Term Care Insurance Contract	Replaced	Yes
Form	Cash Benefit Rider	Approved	Yes
Form	Compound 3% Annual Increase Benefit Rider	Approved	Yes
Form	Compound 5% Annual Increase Benefit Rider	Approved	Yes
Form	Flexible Increase Benefit Rider	Approved	Yes
Form	Limited Premium Payment Period Contingent Nonforfeiture Benefit Rider	Approved	Yes
Form	Nonforfeiture Benefit Rider	Approved	Yes
Form	Restoration of Benefits Rider	Approved	Yes
Form	Return of Premium Upon Death Rider	Approved	Yes
Form	Shared Care Benefit Rider	Approved	Yes
Form	Survivorship Benefit Rider	Approved	Yes

**SERFF Tracking #:**

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Arkansas

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Form</b>	Waiver of Elimination Period for Home Care and Adult Day Care Rider	Approved	Yes
<b>Form (revised)</b>	Application for Individual Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Application for Individual Long-Term Care Insurance	Replaced	Yes
<b>Form</b>	Preliminary Declaration of Insurability Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Declaration of Insurability Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Supplement to Declaration of Insurability Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Residual Benefit Declaration of Insurability for Individual Long-Term Care Insurance	Approved	Yes
<b>Form</b>	Application Change	Approved	Yes
<b>Rate (revised)</b>	Rate Schedules	Approved	Yes
<b>Rate</b>	Rate Schedules	Replaced	Yes

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**State:** Arkansas **Filing Company:** Thrivent Financial for Lutherans  
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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/13/2012
Submitted Date	08/13/2012
Respond By Date	09/13/2012

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Dear Karen Guyette,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*- Long-Term Care Insurance Contract, H-HL-LTC (12) (Form)*

*Comments: The last sentence of the Misstatement of Age provision on page 21 should be removed. Our Misstatement of Age provision stated in ACA 23-85-120 does not allow for this restriction.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*

*Donna Lambert*

SERFF Tracking #:

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## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/15/2012
Submitted Date	08/15/2012

Dear Donna Lambert,

### Introduction:

The following is in reply to your objection letter of 8/13/2012.

### Response 1

#### Comments:

The last sentence of the Misstatement of Age provision on page 21 has been removed as requested.

### Related Objection 1

Applies To:

- Long-Term Care Insurance Contract, H-HL-LTC (12) (Form)

Comments: The last sentence of the Misstatement of Age provision on page 21 should be removed. Our Misstatement of Age provision stated in ACA 23-85-120 does not allow for this restriction.

### Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

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Thrivent Financial for Lutherans

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## Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	H-HL-LTC (12)	POL	Long-Term Care Insurance Contract	Initial	51.000	AR Contract H-HL-LTC (12).pdf	Date Submitted: 08/15/2012 By: Karen Guyette

## Previous Version

1	H-HL-LTC (12)	POL	Long-Term Care Insurance Contract	Initial	51.000	Contract H-HL-LTC (12).pdf	Date Submitted: 08/15/2012 By: Karen Guyette
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No Rate/Rule Schedule items changed.

**Conclusion:**

Thank you for your continued review of this filing.

Sincerely,

Karen Guyette

SERFF Tracking #:

THR-128572645

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name:

Long-Term Care (2012)

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/

## Amendment Letter

Submitted Date: 09/20/2012

Comments:

We believe that we should have bracketed the contract pay types in Section 3 of our Application for Individual Long-Term Care Insurance. It is possible that we may want to cease the "10-Pay" premium payment period for new sales in the future. Therefore, we are submitting a revised application with the contract pay types bracketed and a corrected statement of variability in order to give us this flexibility in the future.

Karen Guyette

Compliance Specialist II

Changed Items:

### Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
27154 N1-12	Application/Enrollment Form	Application for Individual Long-Term Care Insurance	Initial				53.000	Application 27154 N1-12.pdf

### Supporting Document Schedule Item Changes:

User Added -Name: Statement of Variability

Comment: Attached are the following:

- 1) A Statement of Variability for the contract, riders, and application.
- 2) A Statement of Variability for Application Change form 20887A N1-12.

AR LTC SOV.pdf

Application Change SOV.pdf

Submitted Date: 08/08/2012

Comments:

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Company Tracking #:

State:

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Filing Company:

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TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name:

Long-Term Care (2012)

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The form numbers on the rate schedules and actuarial memorandum were mistakenly listed incorrectly. Corrected rate schedules and actuarial memorandum are attached.

Changed Items:

**Rate/Rule Schedule Item Changes:**

Document	Affected Form	Rate	Rate Action Information:	Attach
Name:	Numbers: (Comma Separated list)	Action:		Document:
Rate Schedules	H-HL-LTC (12), HR-HS-SC (12), New HR-HT-CAIB3 (12), HR-HV-CAIB5 (12), HR-HC-CB (12), HR-HF-FIB (12), HR-HN-NF (12), HR-HE-WEP (12), HR-HU-SU (12), HR-HR-RB (12), HR-HP-RP (12)			LTC Rate Schedules.pdf

**Supporting Document Schedule Item Changes:**

Satisfied -Name: Health - Actuarial Justification

Comment:

Std LTC Actuarial Memo.pdf

**State:** Arkansas

**Filing Company:** Thrivent Financial for Lutherans

**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.004 Partnership

**Product Name:** Long-Term Care (2012)

**Project Name/Number:** /

## Note To Filer

**Created By:**

Donna Lambert on 09/20/2012 12:29 PM

**Last Edited By:**

Donna Lambert

**Submitted On:**

09/20/2012 12:29 PM

**Subject:**

Reopen Filing

**Comments:**

The filing is reopened as requested.

---

**State:** Arkansas **Filing Company:** Thrivent Financial for Lutherans  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.004 Partnership  
**Product Name:** Long-Term Care (2012)  
**Project Name/Number:** /

## Note To Reviewer

**Created By:**

Karen Guyette on 09/20/2012 08:26 AM

**Last Edited By:**

Karen Guyette

**Submitted On:**

09/20/2012 08:26 AM

**Subject:**

Request to Re-Open Filing

**Comments:**

Donna,

We believe that we should have bracketed the contract pay types on our Application for Individual Long-Term Care Insurance. It is possible that we may want to cease the "10-Pay" premium payment period for new sales in the future. We have not yet begun to sell; that starts on 10/25. Could you re-open this filing so that we can submit a revised application with the contract pay types bracketed and a corrected statement of variability in order to give us that flexibility in the future? Thanks for your consideration.

Karen Guyette  
Compliance Specialist II

State: Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name: Long-Term Care (2012)

Project Name/Number: /

## Form Schedule

Lead Form Number: H-HL-LTC (12)							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved 08/15/2012	H-HL-LTC (12)	POL	Long-Term Care Insurance Contract	Initial:	51.000	AR Contract H-HL-LTC (12).pdf
2	Approved 08/15/2012	HR-HC-CB (12)	POLA	Cash Benefit Rider	Initial:	57.000	Rider HR-HC-CB (12).pdf
3	Approved 08/15/2012	HR-HT-CAIB3 (12)	POLA	Compound 3% Annual Increase Benefit Rider	Initial:	59.000	Rider HR-HT-CAIB3 (12).pdf
4	Approved 08/15/2012	HR-HV-CAIB5 (12)	POLA	Compound 5% Annual Increase Benefit Rider	Initial:	59.000	Rider HR-HV-CAIB5 (12).pdf
5	Approved 08/15/2012	HR-HF-FIB (12)	POLA	Flexible Increase Benefit Rider	Initial:	59.000	Rider HR-HF-FIB (12).pdf
6	Approved 08/15/2012	HR-HL-LCNF (12)	POLA	Limited Premium Payment Period Contingent Nonforfeiture Benefit Rider	Initial:	50.000	Rider HR-HL-LCNF (12).pdf
7	Approved 08/15/2012	HR-HN-NF (12)	POLA	Nonforfeiture Benefit Rider	Initial:	51.000	Rider HR-HN-NF (12).pdf
8	Approved 08/15/2012	HR-HR-RB (12)	POLA	Restoration of Benefits Rider	Initial:	58.000	Rider HR-HR-RB (12).pdf
9	Approved 08/15/2012	HR-HP-RP (12)	POLA	Return of Premium Upon Death Rider	Initial:	59.000	Rider HR-HP-RP (12).pdf
10	Approved 08/15/2012	HR-HS-SC (12)	POLA	Shared Care Benefit Rider	Initial:	55.000	Rider HR-HS-SC (12).pdf
11	Approved 08/15/2012	HR-HU-SU (12)	POLA	Survivorship Benefit Rider	Initial:	55.000	Rider HR-HU-SU (12).pdf

State: Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name: Long-Term Care (2012)

Project Name/Number: /

## Lead Form Number: H-HL-LTC (12)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
12	Approved 08/15/2012	HR-HE-WEP (12)	POLA	Waiver of Elimination Period for Home Care and Adult Day Care Rider	Initial:	60.000	Rider HR-HE-WEP (12).pdf
13	Approved 09/21/2012	27154 N1-12	AEF	Application for Individual Long-Term Care Insurance	Initial:	53.000	Application 27154 N1-12.pdf
14	Approved 08/15/2012	27253 N1-12	AEF	Preliminary Declaration of Insurability Long-Term Care Insurance	Initial:	52.000	Application 27253 N1-12.pdf
15	Approved 08/15/2012	27158 N1-12	AEF	Declaration of Insurability Long-Term Care Insurance	Initial:	59.000	Application 27158 N1-12.pdf
16	Approved 08/15/2012	27159 N1-12	AEF	Supplement to Declaration of Insurability Long-Term Care Insurance	Initial:	70.000	Application 27159 N1-12.pdf
17	Approved 08/15/2012	27507 N1-12	AEF	Residual Benefit Declaration of Insurability for Individual Long-Term Care Insurance	Initial:	53.000	Application 27507 N1-12.pdf
18	Approved 08/15/2012	20887A N1-12	OTH	Application Change	Initial:	57.000	Application Change 20887A N1-12.pdf

## Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

THR-128572645

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name:

Long-Term Care (2012)

Project Name/Number:

/

<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages
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This contract is intended to be a qualified long-term care insurance contract pursuant to the Internal Revenue Code Section 7702B(b).

This certificate of membership and long-term care insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the Application signed by the applicant and the payment of the initial premium shown in the Contract Schedule. We will pay benefits according to the provisions of this contract. Coverage starts at 12:01 a.m. on the Date of Issue. It ends at 11:59 p.m. on the day this contract terminates.

**This contract is guaranteed renewable for life. Premium rates for this contract are subject to change.** This contract will remain in force subject to its Termination provision. We cannot cancel this contract or reduce its benefits unless required to do so by federal or state law. After this contract has been in force for five years, we may change the premium for this contract but not more frequently than once a year. Any change will apply to all contracts issued in your state on this contract form. We will not change the premium due to changes in your health or due to any claims on this contract. We will give you at least 60 days notice of any change in premium.

**Caution: The issuance of this contract is based on your responses to the questions on your Application. A copy of your Application is attached to this contract. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your contract. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact us at 4321 North Ballard Road, Appleton, Wisconsin 54919-0001.**

**Right to Cancel. Please read this contract carefully.** You may cancel this contract for any reason before midnight of the 30th day after you first receive it. Do this by (1) mailing or delivering notice of cancellation to our Service Center or to the representative through whom you bought it and (2) returning this contract. Notice given by mail and return of this contract by mail are effective on being postmarked, properly addressed and postage prepaid. If you cancel this contract, it will be deemed void from the beginning and the parties will be in the same position as if no contract had been issued. Within 30 days after we receive notice of cancellation and the returned contract, we will refund all premiums paid directly to the payer.

**Notice to Buyer: This contract may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all contract limitations.**

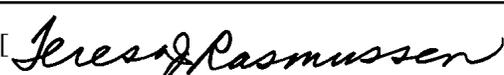
This is not Medicare supplement insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us.

**This is a long-term care insurance contract with benefits for residential facility, home and community-based care. Guaranteed renewable for life. Premiums subject to change. Annual dividends payable if earned.**

**Service Center:**  
**Thrivent Financial for Lutherans**  
[ 4321 North Ballard Road ]  
[ Appleton, WI 54919-0001 ]  
**Telephone [ (800) 847-4836 ]**  
**www.thrivent.com**

Signed for the Society

President [  ]

Secretary [  ]

INSURED: [ JOHN A DOE ]

AGE: [ 65 ]

SEX: [ MALE ]

CONTRACT NUMBER: [ N0012345 ]

DATE OF ISSUE: [ SEPTEMBER 01, 2012 ]

H-HL-LTC (12)

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## 1. DEFINITIONS AND GLOSSARY

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This section includes definitions of terms that are used throughout this contract and section references to definitions of terms that appear only in one section of this contract. Defined terms are capitalized throughout the contract except for we, our, us, you, your and yours.

**Activities of Daily Living.** See Section 2.2 Chronically Ill.

**Adult Day Care.** See Section 3.3 Adult Day Care Benefit.

**Adult Day Care Facility.** See Section 3.3 Adult Day Care Benefit.

**Application.** Your application(s) and all application supplements and amendments to the Application.

**Assisted Living Facility.** See Section 3.1 Residential Care Facility Benefit.

**Available Benefit.** The Available Benefit is shown in the Contract Schedule. It is the total benefit available to you during your lifetime. The Available Benefit is reduced by the amounts we pay under Sections 3 Long-Term Care Benefits and 4 Ancillary Long-Term Care Benefits. When your Available Benefit reaches zero, this contract will terminate as provided in Section 10.11 Termination.

**Benefit Multiplier.** The Benefit Multiplier for this contract is shown in the Contract Schedule. It is used to determine the Available Benefit.

**Calendar Week.** A 7-day period beginning on Sunday and ending on Saturday.

**Care Coordinator.** See Section 2.4 Care Coordinator Services.

**Chronically Ill.** See Section 2.2 Chronically Ill.

**Cognitive Impairment.** See Section 2.2 Chronically Ill.

**Conditions on Eligibility for Benefits.** See Section 2.1 Limitations or Conditions on Eligibility for Benefits.

**Contract Anniversary.** The same month and day of each year after issue as in the Date of Issue of this contract.

**Date of Issue.** The Date of Issue of this contract as shown in the Contract Schedule.

**Doctor.** A practitioner of the healing arts who is licensed as a doctor and is acting within the lawful scope of his or her license.

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**1. DEFINITIONS AND GLOSSARY**

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(continued)

**Elimination Period.** The Elimination Period is shown in the Contract Schedule. It begins on the first day after the Date of Issue of this contract on which a Chronically Ill Insured receives Qualified Long-Term Care Services of the types covered under Section 3 (hereafter called Qualifying Services). That day and any following days in the same Calendar Week will be credited toward the Elimination Period. For any subsequent Calendar Week during which you receive Qualifying Services:

- 1) On the first day on which you receive Qualifying Services that week, we will credit that day and any prior days of the same Calendar Week; and
- 2) On each day following in the same Calendar Week, we will credit that day regardless of whether you receive Qualifying Services on that day.

If you do not receive Qualifying Services during a Calendar Week, no days of that week will be credited toward the Elimination Period.

The last day of the Elimination Period is the first day on which the number of days credited meets or exceeds the number of days shown for the Elimination Period in the Contract Schedule. You must meet the Elimination Period requirement only once during your lifetime.

Weeks during which Qualifying Services are received do not need to be consecutive to be credited toward the Elimination Period.

For benefits subject to the Elimination Period, no benefits are payable for days that are credited toward the Elimination Period.

**Home Care Services.** See Section 3.4 Home Care Benefit.

**Homemaker Services.** See Section 3.4 Home Care Benefit.

**Hospice.** See Section 3.1 Residential Care Facility Benefit.

**Hospice Care Services.** Qualified Long-Term Care Services that are:

- 1) Designed to ease the physical, emotional, social and spiritual discomforts of persons who are in the last phases of life due to terminal illness; and
- 2) Provided either in a person's place of residence or in a Residential Care Facility.

**Informal Caregiver.** A person who:

- 1) Provides care for a Chronically Ill person who is not a resident of a Residential Care Facility; and
- 2) Receives no compensation for providing such care.

**Insured.** The person named as the Insured in the Contract Schedule.

**Issue Age.** Your age as shown in the Contract Schedule.

**Licensed Health Care Practitioner.**

- 1) A physician as defined in Section 1861(r)(1) of the Social Security Act;
- 2) A registered professional nurse;
- 3) A licensed social worker; or
- 4) Any person who meets requirements for a Licensed Health Care Practitioner which may be set forth by the federal Secretary of the Treasury.

**Maximum Monthly Benefit.** The Maximum Monthly Benefit is the limit on the amount that we will pay under Section 3 Long-Term Care Benefits for the combined expenses incurred in a single calendar month. The Maximum Monthly Benefit is shown in the Contract Schedule.

**1. DEFINITIONS AND GLOSSARY**

(continued)

If benefits first become payable under Section 3 Long-Term Care Benefits on a day other than the first day of a calendar month, the amount of the Maximum Monthly Benefit for that month will be prorated based on the number of days remaining in the calendar month. If benefits under Section 3 Long-Term Care Benefits are no longer payable, the Maximum Monthly Benefit will be prorated in the first month when benefits again become payable.

**Medicare.** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**Monthly Contract Anniversary.** The same day of the month of each month after issue of this contract as in the Date of Issue.

**Notice.** A request signed by you and received in good order by us at our Service Center.

**Nursing Home.** See Section 3.1 Residential Care Facility Benefit.

**Plan of Care.** See Section 2.3 Qualified Long-Term Care Services.

**Qualified Long-Term Care Services.** See Section 2.3 Qualified Long-Term Care Services.

**Residential Care Facility.** See Section 3.1 Residential Care Facility Benefit.

**Respite Care.** See Section 4.1 Respite Care Benefit.

**Skilled Nursing Services.** Services provided by a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.).

**we, our, us, Society.** Thrivent Financial for Lutherans.

**you, your and yours.** The Insured named in the Contract Schedule.

**2. ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

**2.1 LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS.** To be eligible for benefits under this contract, all of the following Conditions on Eligibility for Benefits must be met:

- 1) You are Chronically Ill and receive Qualified Long-Term Care Services;
- 2) For benefits subject to the Elimination Period, the services are received after that period has ended; and
- 3) Coverage is not excluded under Section 7 Exceptions and Limitations.

**2.2 CHRONICALLY ILL.** On any given day, you are Chronically Ill if a Licensed Health Care Practitioner has, within the 12-month period preceding that day, certified in writing that you have:

- 1) A Physical Impairment that is expected to last at least 90 days; or
- 2) A Cognitive Impairment.

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**2. ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

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(continued)

A **Physical Impairment** is an impairment that prevents you from performing two or more of the following Activities of Daily Living without the Substantial Assistance of another person:

- 1) **Bathing.** Washing oneself in a tub or shower, including getting in or out of the tub or shower, or by sponge bath.
- 2) **Continence.** Maintaining control of bowel and bladder function or, if unable to do so, taking care of the personal hygiene associated with incontinence, including caring for a catheter or colostomy bag.
- 3) **Dressing.** Putting on and taking off all items of clothing and any necessary braces, fasteners or prostheses.
- 4) **Eating.** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or, if necessary, by feeding tube or intravenously. Eating does not include preparing meals.
- 5) **Transferring.** Moving into or out of a bed, chair or wheelchair.
- 6) **Using the Toilet.** Getting to and from the toilet, transferring on and off the toilet and performing the associated personal hygiene.

When a Licensed Health Care Practitioner has certified that you are unable to perform Activities of Daily Living for an expected period of at least 90 days due to a Physical Impairment and you are receiving Qualified Long-Term Care Services, the certification may not be rescinded and additional certifications may not be performed until after the 90-day period.

**Substantial Assistance** means hands-on assistance or standby assistance. Hands-on assistance is the physical assistance of another person without which one would not be able to perform an Activity of Daily Living. Standby assistance is the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to oneself while performing an Activity of Daily Living.

A **Cognitive Impairment** is an impairment of the mind that:

- 1) Is comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia;
- 2) Is measured by clinical evidence and standardized tests that reliably measure impairment in your short-term or long-term memory, orientation as to person, place or time, deductive or abstract reasoning, and judgment as to safety awareness; and
- 3) Results in the need for continual supervision (which may include cuing by verbal prompting, gestures or other demonstrations) by another person to protect you from threats to your health or safety (such as may result from wandering).

**2.3 QUALIFIED LONG-TERM CARE SERVICES.**

Qualified Long-Term Care Services are necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services and Maintenance or Personal Care Services that are:

- 1) Required because you are Chronically Ill; and
- 2) Provided pursuant to a Plan of Care.

This contract covers only Qualified Long-Term Care Services.

**2. ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

(continued)

**Maintenance or Personal Care Services** means any services that are provided primarily to:

- 1) Assist a Chronically Ill person with the Activities of Daily Living that he or she is unable to perform without assistance; or
- 2) Protect a Chronically Ill person from threats to health and safety due to a Cognitive Impairment.

A **Plan of Care** is a written document that:

- 1) Is prepared and signed by a Licensed Health Care Practitioner in accordance with accepted standards of practice;
- 2) Prescribes Qualified Long-Term Care Services that are consistent with an Assessment of your impairment; and
- 3) Includes services or treatment that could not be omitted without adversely affecting your health.

We retain the right to discuss the Plan of Care with the Licensed Health Care Practitioner who prepared it. We may also verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a person who is Chronically Ill. The Plan of Care must be updated as your needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more often than once every 30 days. We will make a copy of the current Plan of Care available to your Doctor, when requested. You may have only one Plan of Care in effect at any time.

An **Assessment** means an evaluation done by a Licensed Health Care Practitioner to determine or verify that you are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

**2.4 CARE COORDINATOR SERVICES.** A Care Coordinator can help develop your required Plan of Care. We will refer your need for a Plan of Care to a Care Coordinator if:

- 1) You are Chronically Ill; and
- 2) You contact us to request a referral.

There is no cost to you for the services provided by a Care Coordinator referred by us. These services are not subject to the Elimination Period.

A **Care Coordinator** is someone with training and expertise in geriatric case management. Services provided by a Care Coordinator include, but are not limited to:

- 1) Identifying the services needed by a Chronically Ill person;
- 2) Locating local caregivers and care facilities available to provide those services;
- 3) Assisting in the development, implementation, and coordination of a Plan of Care; and
- 4) Monitoring the person's ongoing care.

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### 3. LONG-TERM CARE BENEFITS

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Benefits provided in this section are subject to the Elimination Period, the Maximum Monthly Benefit and the Available Benefit.

#### 3.1 RESIDENTIAL CARE FACILITY BENEFIT.

After the Elimination Period has ended, we will pay the expenses that you incur for Qualified Long-Term Care Services billed to you by a Residential Care Facility if:

- 1) You meet all of the Conditions on Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) You receive Qualified Long-Term Care Services while you are a resident in the facility.

Expenses payable under this provision include charges for room, board, personal care and Skilled Nursing Services provided by the facility to the extent that such charges are for Qualified Long-Term Care Services.

**Residential Care Facility** means a Nursing Home, Assisted Living Facility or Hospice. Residential Care Facility does not include that part of any facility that is primarily:

- 1) A clinic, hospital or sanatorium;
- 2) A subacute care or rehabilitation hospital;
- 3) A sheltered living accommodation, a residence home or a similar living arrangement; or
- 4) A home or facility that operates primarily for the treatment of alcoholism, drug addiction or a mental or nervous disorder.

A **Nursing Home** is a facility or that part of one that provides room, board and inpatient care for its residents. A Nursing Home must:

- 1) Be licensed as a nursing home by the appropriate state or federal agency;
- 2) Provide Skilled Nursing Services under the supervision of a Doctor or a registered graduate nurse (R.N.);

- 3) Have a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.) on duty or on call at all times and at least one such nurse who is employed full time on the day shift; and
- 4) Keep a record of the care provided to each resident.

An **Assisted Living Facility** is a facility or that part of one that provides room, board and personal care services for its residents. An Assisted Living Facility must:

- 1) Be licensed or certified by the appropriate governing agency;
- 2) Provide 24-hour-a-day care and services sufficient to support the needs of persons who are Chronically Ill;
- 3) Have a trained and ready-to-respond employee on duty at all times;
- 4) Keep a record of the care provided to each resident;
- 5) Provide its residents with three meals a day;
- 6) Have appropriate methods and procedures for providing residents help in managing prescribed medications; and
- 7) Have established procedures for obtaining appropriate aid in the event of a medical emergency.

An adult congregate care facility, personal boarding care facility, dementia care facility or similarly named facility will qualify as an Assisted Living Facility if it meets all of the above requirements. If a facility has multiple licenses or multiple purposes, only that part of the facility that meets all of these requirements will qualify as an Assisted Living Facility.

A **Hospice** is a facility or that part of one that provides room, board and inpatient palliative care for persons who are in the last phases of life due to terminal illness. A Hospice must be licensed or certified to provide Hospice Care Services by the appropriate governing agency where the care is provided. Hospice Care Services are defined in Section 1 Definitions and Glossary.

**3. LONG-TERM CARE BENEFITS**

(continued)

**3.2 BED RESERVATION FEATURE.** The Residential Care Facility Benefit will not be interrupted by a temporary absence from the facility where you are a resident:

- 1) That is immediately preceded by a day on which you incur expenses that are eligible for payment under Section 3.1 Residential Care Facility Benefit; and
- 2) During which you are absent from the facility for any reason but continue to be charged by the facility for Qualified Long-Term Care Services.

If the Elimination Period has not yet ended, the crediting of days toward the Elimination Period will not be interrupted by a temporary absence as described above.

Temporary absences are limited to a total of 60 days per calendar year.

**3.3 ADULT DAY CARE BENEFIT.** After the Elimination Period has ended, we will pay the expenses that you incur for Adult Day Care if:

- 1) You meet all of the Conditions on Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) You receive Adult Day Care at an Adult Day Care Facility.

**Adult Day Care** means social and health-related Qualified Long-Term Care Services for six or more individuals that is provided during the day in a community group setting. The purpose of Adult Day Care is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

An **Adult Day Care Facility** is a facility that provides Adult Day Care in a non-residential setting to persons who are Chronically Ill. An Adult Day Care Facility must:

- 1) Be licensed or certified to provide Adult Day Care by the appropriate governing agency where the facility operates; or
- 2) If licensing or certification is not required where the facility operates:
  - a) Retain enough full-time staff to maintain no more than an 8 to 1 client-to-staff ratio; and
  - b) Have established procedures for obtaining appropriate aid in the event of a medical emergency.

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**3. LONG-TERM CARE BENEFITS**

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(continued)

**3.4 HOME CARE BENEFIT.** After the Elimination Period has ended, we will pay the expenses that you incur for Home Care Services if:

- 1) You meet all of the Conditions on Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) You receive Home Care Services.

**Home Care Services** are Qualified Long-Term Care Services that are:

- 1) Necessary to enable you to continue to live safely in your residence; and
- 2) Provided in your place of residence by:
  - a) An employee of a Home Health Care Agency; or
  - b) A person who has:
    - i) The training and supervision appropriate for the services provided; and
    - ii) When legally required, the appropriate license or certification to provide the services.

Home Care Services include:

- 1) Homemaker Services;
- 2) Home Health Aide services;
- 3) Skilled Nursing Services;
- 4) Nutritional and dietary services;
- 5) Physical, occupational, speech and respiratory therapy; and
- 6) Hospice Care Services.

A **Home Health Care Agency** is an agency that:

- 1) Provides care designed to meet the needs of persons who are Chronically Ill; and
- 2) Is licensed or certified to provide such care by the appropriate governing agency where the care is provided.

**Homemaker Services** are Qualified Long-Term Care Services that consist of help with activities necessary to maintain a household when you cannot perform them due to an impairment and an Informal Caregiver is not available. Homemaker Services include routine house-cleaning, preparing meals, laundry, and shopping for essentials.

A **Home Health Aide** is a health-care worker who has been trained to supervise and assist Chronically Ill persons in:

- 1) Performing simple health care tasks;
- 2) Maintaining personal hygiene;
- 3) Managing medications; and
- 4) Performing Activities of Daily Living.

**Skilled Nursing Services and Hospice Care Services** are defined in Section 1 Definitions and Glossary.

**3. LONG-TERM CARE BENEFITS**

(continued)

**3.5 ALTERNATE CARE BENEFIT.** If your Plan of Care prescribes Qualified Long-Term Care Services that are not covered by this contract, we may pay benefits for such services if:

- 1) The prescribed services are a cost-effective alternative to services covered by this contract; and
- 2) You and we agree to a written alternate care benefit agreement. Any agreement will specify:
  - a) The Qualified Long-Term Care Services to be covered; and

- b) Whether the services will be covered under Section 3 Long-Term Care Benefits or Section 4 Ancillary Long-Term Care Benefits.

Benefits will be paid according to the terms of this contract. No benefits will be paid for services provided prior to the date of the agreement.

**4. ANCILLARY LONG-TERM CARE BENEFITS**

This contract's Ancillary Long-Term Care Benefits are described in the provisions below. Each Ancillary Long-Term Care Benefit is subject to the Available Benefit and its own separate benefit limit as shown in the Contract Schedule. Ancillary Benefits are not subject to the Elimination Period or the Maximum Monthly Benefit.

**4.1 RESPITE CARE BENEFIT.** We will pay the Respite Care Benefit if:

- 1) You meet all of the Conditions for Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) You receive Respite Care.

The amount payable will be the expense that you incur for Respite Care or, if less, the amount equal to:

- 1) The Respite Care Benefit Limit in effect on the day the expense was incurred; less
- 2) The total amount previously paid by this contract for Respite Care received in the same calendar year.

**Respite Care** means Qualified Long-Term Care Services that are:

- 1) Designed to relieve an Informal Caregiver; and
- 2) Provided on a short-term basis in a Residential Care Facility, an Adult Day Care Facility or in your home as Home Care Services.

If a Calendar Week includes one or more days for which we pay benefits for Respite Care, no days of that week will be credited toward the Elimination Period.

**4.2 EQUIPMENT/HOME MODIFICATION BENEFIT.** We will pay the Equipment/Home Modification Benefit if:

- 1) You meet all of the Conditions for Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) You receive Special Equipment or Home Modifications.

The amount payable will be the expense that you incur for Qualified Long-Term Care Services in the form of Special Equipment or Home Modification or, if less, the amount equal to:

- 1) The Equipment/Home Modification Benefit Limit in effect on the day the expense was incurred; less
- 2) The total amount previously paid by this contract for Special Equipment and Home Modifications.

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**4. ANCILLARY LONG-TERM CARE BENEFITS**

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(continued)

The Equipment/Home Modification Benefit only provides coverage for items that are outlined in your Plan of Care and are solely provided to assist you to remain in your home.

**Special Equipment is:**

- 1) Therapeutic equipment such as a hospital bed, wheelchair, crutches, or walker;
- 2) Safety-related equipment such as a medical alert system; and
- 3) Any other medical equipment that is specified in your Plan of Care.

**Home Modifications include:**

- 1) Home safety checks to evaluate your home to determine if it is a physically safe environment for you and provide recommendations for home modifications;
- 2) Accessibility changes to your home such as a ramp, chair-lift, or alterations to your bathroom or kitchen to accommodate a wheelchair;
- 3) Safety-related changes to your home such as the installation of grab bars or railings; and
- 4) Any other changes to your home that are specified in your Plan of Care.

**4.3 CAREGIVER TRAINING BENEFIT.** We will pay the Caregiver Training Benefit if:

- 1) You meet all of the Conditions for Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) Caregiver Training is received by your Informal Caregiver.

The amount payable will be the expense incurred for Qualified Long-Term Care Services in the form of Caregiver Training or, if less, the amount equal to:

- 1) The Caregiver Training Benefit Limit in effect on the day the expense was incurred; less
- 2) The total amount previously paid by this contract for Caregiver Training.

**Caregiver Training** is training that is:

- 1) Given to your Informal Caregiver as specified in your Plan of Care; and
- 2) Provided by a person who is licensed, certified or otherwise qualified to provide training to an Informal Caregiver.

**4.4 INTERNATIONAL CARE BENEFIT.** We will pay the International Care Benefit if:

- 1) You meet all of the Conditions for Eligibility for Benefits as specified in Section 2.1 Limitations or Conditions on Eligibility for Benefits; and
- 2) You receive International Care.

The amount payable will be the expense that you incur for International Care or, if less, the amount equal to:

- 1) The International Care Benefit Limit in effect on the day the expense was incurred; less
- 2) The total amount previously paid by this contract for International Care.

**4. ANCILLARY LONG-TERM CARE BENEFITS**

(continued)

**International Care** means Qualified Long-Term Care Services that are:

- 1) Received outside the United States, its territories and possessions; and
- 2) Would be covered under Sections 3.1 Residential Care Facility Benefit, 3.3 Adult Day Care Benefit or 3.4 Home Care Benefit if the care were provided in the United States.

To receive payment for International Care you must provide us with the following written documentation in English:

- 1) Certification from a U.S. Licensed Health Care Practitioner that you were Chronically Ill and received the services for which you are submitting a notice of claim;
- 2) Properly completed claim forms and proof of care in the form of fully itemized bills and evidence that you remitted payment for the services in your claim;

- 3) Copies of medical records which we deem necessary to support your claim; and
- 4) Copy of a passport, airline ticket or other proof acceptable to us that you were outside the United States, its territories and possessions, and in the specific location from which the reported care was provided.

We may require updated documentation on a periodic basis, but not more often than 30 days.

Benefits will be paid to you in U.S. dollars. Any foreign exchange rate will be determined by us based on the time the expense was incurred. Expenses will not be covered in countries where payment would violate economic, financial or trade sanctions imposed by the U.S. or the U.N.

**5. WAIVER OF PREMIUM BENEFIT**

After the Elimination Period has ended, as of the date you first incur expenses for which benefits are payable under Section 3 Long-Term Care Benefits we will:

- 1) Waive the portion of any premiums paid for coverage beyond that date; and
- 2) Waive any premiums that come due while you continue to incur expenses for which benefits are payable under Section 3.

If benefits under Section 3 are no longer payable:

- 1) Premiums will no longer be waived; and
- 2) You must resume paying premiums in order to keep this contract in force.

When we determine that premiums will no longer be waived we will notify you and send a premium notice with the premium due date. Premiums will be calculated from the date that payable expenses under Section 3 were last incurred. The retained portion of any premium paid by you for the period during which premiums were waived, if any, may be applied to pay any premium that later comes due.

This benefit will apply each time benefits under Section 3 Long-Term Care Benefits again become payable.

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## 6. CONTINGENT NONFORFEITURE BENEFIT

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### 6.1 CONTINGENT NONFORFEITURE BENEFIT.

If the Contingent Nonforfeiture Benefit is triggered, your coverage will continue as paid-up coverage. If the benefit is triggered by premium default, the paid-up coverage will be effective on the date the grace period ends. Otherwise, paid-up coverage will be effective on the date of your Notice to cancel this contract.

Benefits will be paid subject to all of the conditions and limitations of this contract. No increases will be provided under any increase benefit rider on or after the date paid-up coverage becomes effective. All riders on this contract will terminate on the date paid-up coverage becomes effective.

The paid-up coverage will have an Available Benefit equal to the lesser of:

- 1) The Nonforfeiture Credit (see Section 6.2); and
- 2) The Available Benefit in effect immediately before the date paid-up coverage becomes effective.

The Available Benefit under the paid-up coverage may be used for all care and services covered under the terms of this contract. The Available Benefit will be reduced by the amounts that we pay under the paid-up coverage. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

**6.2 NONFORFEITURE CREDIT.** The Nonforfeiture Credit is equal to the greater of:

- 1) The total of all premiums paid by you and applied to this contract; and
- 2) The Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective.

Premiums paid by you do not include premiums waived by us or reduced by dividends.

**6.3 BENEFIT TRIGGER.** The Contingent Nonforfeiture Benefit will be triggered if:

- 1) We increase the premium payable for this contract;
- 2) The new premium represents a substantial increase in premium as defined below; and
- 3) Within 120 days after the due date of the new premium, either:
  - a) This contract terminates due to premium default; or
  - b) You give Notice to cancel this contract. The date of Notice is the date we receive it or, if later, the date you specify.

**6. CONTINGENT NONFORFEITURE BENEFIT**

(continued)

A substantial premium increase is an increase that results in a cumulative percentage increase in premiums since the Date of Issue that equals or exceeds the percentage shown below:

**TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE**

<u>Issue Age</u>	<u>Percentage Increase</u>	<u>Issue Age</u>	<u>Percentage Increase</u>
29 and under	200%	72	36%
30 to 34	190%	73	34%
35 to 39	170%	74	32%
40 to 44	150%	75	30%
45 to 49	130%	76	28%
50 to 54	110%	77	26%
55 to 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90+	10%

On or before the effective date of a substantial premium increase we will notify you of your option to:

- 1) Reduce the benefits provided by this contract without additional underwriting, to the extent allowed by Section 10.3 Changing Your Coverage, so the contract may be continued without an increase in premium;
- 2) Terminate this contract by Notice within 120 days after the new premium is due and thereby trigger the Contingent Nonforfeiture Benefit; or
- 3) Continue this contract by paying the new premium.

We will also notify you that premium default within 120 days after the effective date of the increased premium will be deemed to be an election of the Contingent Nonforfeiture Benefit.

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## 7. EXCEPTIONS AND LIMITATIONS

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**7.1 EXCEPTIONS.** This contract does not pay benefits for charges billed by a Doctor or charges for prescription drugs.

In addition, this contract does not cover services:

- 1) Outside of the United States, its territories and possessions, except as provided in Section 4.4 International Care Benefit.
- 2) Necessary due to an attempt at suicide, while sane or insane, or an intentionally self-inflicted injury.
- 3) Provided for the treatment of alcoholism or drug addiction.
- 4) Care or services provided by an Immediate Family Member unless:
  - a) He or she is a regular employee of a facility or agency that is providing the treatment, services or care;
  - b) The facility or agency receives the payment for the treatment, service or care and he or she receives no compensation other than the normal compensation for employees in his or her job category; and
  - c) He or she has no ownership or financial interest in the facility or agency providing the treatment, services or care.

An **Immediate Family Member** means your spouse or Partner and anyone who is related to you, your spouse or Partner by blood, adoption or marriage (including step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, nephew or niece.

As used in this provision, **Partner** means a state-recognized partner or a person who is in a committed relationship with you, has been living with you for at least three consecutive years and is committed to sharing expenses with you.

- 5) For which benefits are payable under any state or federal workers' compensation, employer's liability or occupational disease law.

**7.2 MEDICARE NON-DUPLICATION.** This contract does not pay benefits for expenses that are reimbursable under Medicare or would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

**7.3 COORDINATION WITH OTHER COVERAGE ISSUED BY US.** If an expense covered under this contract is also covered by other contracts or riders issued by us, the amount payable for that expense under this contract will be reduced by the sum of the amounts that are paid for that expense under all other coverage issued by us before the Date of Issue of this contract. Any such reduction will be applied before this contract's Maximum Monthly Benefit is applied. For coverage that pays on a fixed indemnity basis, "amounts that are paid" means fixed amounts that we pay as a result of an expense being incurred.

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## 8. CLAIMS

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**8.1 NOTICE OF CLAIM.** A notice of claim must be given to us at our Service Center within 30 days after a covered loss starts or as soon after this as reasonably possible. Notice should include your name and contract number.

**8.2 CLAIM FORMS.** When we receive your notice of claim, we will send you any forms necessary for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 8.3 Proofs of Loss.

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**8. CLAIMS**

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(continued)

**8.3 PROOFS OF LOSS.** Proof of loss must be given to us at our Service Center. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

**8.4 TIME OF PAYMENT OF CLAIMS.** We will pay benefits for losses covered under this contract as soon as we receive sufficient proof of loss.

**8.5 PAYMENT OF CLAIMS.** Benefits will be paid to you or to the health care provider to whom you have assigned benefits. Any benefits payable to you that are unpaid at your death will be paid to your estate.

**8.6 EXAMINATIONS.** In addition to other proof of loss, we may require you to be examined by a Licensed Health Care Practitioner as often as reasonably necessary while a claim is pending or being paid. Examinations that we require under this provision will be at our expense.

**8.7 OVERPAYMENT OF BENEFITS.** If we pay benefits under this contract that you were not entitled to receive, you must reimburse us for the overpayment. We may recover any amounts not repaid by deducting those amounts from future benefits payable to you or by any other reasonable means.

**8.8 BENEFIT APPEALS PROCEDURE.** We will notify you if your claim, or any part of your claim, is denied. If you disagree with our claim decision, you may appeal our decision by writing to our Service Center. You may also request that we make available to you information related to the denial. Your written appeal request (no special form required) should state why you think our decision is wrong and other factors you think we should take into consideration. You should include the names, addresses, and phone numbers of providers you think we should contact to obtain more information about treatment, care or services you received. You may authorize someone to act for you in this appeal process. We will notify you of our determination after we have reviewed your appeal.

If all or part of your appeal involves a determination of whether or not you were Chronically Ill, you also have the right to an independent review. In addition to other dispute resolution mechanisms available to you as a member of Thrivent, within 120 days following the receipt of our written appeal determination that you were not Chronically Ill, you may send us a written request for a review by an independent review organization, paid for by us. We will initiate the review by an independent review organization authorized by the state within 5 business days of receiving the request.

**8.9 LEGAL PROCEEDINGS.** No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years from the time written proof of loss is required to be given.

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**9. PREMIUMS AND REINSTATEMENT**

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**9.1 PREMIUM PAYMENTS.** The Initial Premium amount and its Interval of Payment are shown in the Contract Schedule. The Initial Premium is due and payable on the Date of Issue. Each subsequent premium is due on the first day of its Interval of Payment. Premiums are payable at our Service Center.

**9.2 PREMIUM BILLING.** We will send premium billings based upon the Interval of Payment that you request. Subject to our published rules, you may change the Interval of Payment or the method of billing by giving Notice.

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**9. PREMIUMS AND REINSTATEMENT**

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(continued)

**9.3 CHANGE OF PREMIUM PAYMENT PERIOD.**

If this contract does not have a lifetime premium payment period, you may change it to a lifetime premium payment period, subject to the following:

- 1) You must submit Notice to us at our Service Center.
- 2) The effective date of the change will be the date shown in the Contract Schedule that we will send to you.
- 3) Premiums for the change will be based on your Issue Age.

**9.4 PREMIUM IN DEFAULT AND GRACE**

**PERIOD.** Any premium not paid on or before the date it is due or payable is a premium in default. Except for the first premium, you may pay the premium in default within a grace period of 60 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate on the later of:

- 1) The first day following the grace period; and
- 2) The 31<sup>st</sup> day after we have given notice of termination as specified in Section 9.5 Unintentional Lapse.

**9.5 UNINTENTIONAL LAPSE.** You have the right to designate at least one person other than yourself to receive notice of termination for nonpayment of premium. You may change your designation at any time by sending Notice to our Service Center. We will notify you of your right to change this designation once every two years. After a premium remains in default for 30 days, we will give this notice by first class United States mail to you and any persons whom you have designated to receive such notice. This notice will include a reminder of your right to reduce coverage and premiums. Notice will be deemed to have been given as of five days after the date we mail it.

**9.6 REINSTATEMENT.** If this contract terminates at the end of the grace period for nonpayment of premiums, you may reinstate the contract within six months after the end of the grace period. To do this, any premiums in default must be paid. This contract is reinstated when we accept the payment, unless we also require a reinstatement application or written proof that you have been Chronically Ill.

When an application is required, we must give you notice of approval or disapproval within 45 days after we receive the application. We will reinstate the contract as soon as it is approved. If we do not notify you within the 45 day period, the contract will be automatically reinstated on the 45<sup>th</sup> day.

If you were Chronically Ill on the date the unpaid premium was due, you may reinstate the contract without application within six months after the end of the grace period. To do this, any premiums in default must be paid and written proof that you were Chronically Ill must be given to us at our Service Center. We will reinstate the contract as soon as we receive both payment and sufficient proof of your illness.

The reinstated coverage will be effective on the date your contract terminated for nonpayment of premium. All rights that you or we had immediately before the default in premium payment again apply, subject to any provisions endorsed on or attached to this contract when reinstated. Section 10.4 Time Limit on Certain Defenses will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement, if any.

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## 10. GENERAL PROVISIONS

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**10.1 ENTIRE CONTRACT.** The Entire Contract consists of:

- 1) This contract including any attached riders, amendments or endorsements;
- 2) The Application attached to this contract; and
- 3) The Articles of Incorporation and Bylaws of the Society and all amendments to them. Benefits will not be reduced or eliminated by any future amendments to our Articles of Incorporation or Bylaws.

**10.2 CHANGE OF CONTRACT.** No change to this contract is valid unless it is made in writing and signed by our President or Secretary. No agent has the authority to change the contract or waive any of its provisions.

The provisions of this contract will be construed to be consistent with federal tax rules. Changes in tax laws may require this contract to be amended in order for it to remain tax-qualified. If such changes occur we will offer you the necessary amendment. Rejecting an amendment may result in this contract no longer being tax-qualified. For information regarding federal tax laws you are advised to consult a tax advisor.

**10.3 CHANGING YOUR COVERAGE.** To request changes to your coverage contact us at our Service Center.

You may request to decrease your coverage by:

- 1) Decreasing the Maximum Monthly Benefit or Benefit Multiplier of this contract. A decrease in the Maximum Monthly Benefit will also decrease this contract's Available Benefit and Ancillary Benefit Limits. A decrease in the Benefit Multiplier will decrease the Available Benefit.
- 2) Lengthening the Elimination Period of this contract.
- 3) Terminating an optional rider for which an additional premium is charged.

For decreases in coverage:

- 1) The decrease will be subject to our issue and participation limits in effect on the date of your request.
- 2) The effective date of the decrease and revised premium will be shown in the Contract Schedule that we will send to you.
- 3) The premium for the decreased coverage will be based on the age used to determine the premiums for the coverage currently in force.

If this contract has a lifetime premium payment period, you may request to increase your coverage or add a rider, if the rider is available subsequent to issue of this contract. An increase will be subject to evidence of insurability and our issue and participation limits in effect on the date of your request. Premiums for the increased coverage will be based on your age at the time of the increase.

### 10.4 TIME LIMIT ON CERTAIN DEFENSES.

**Misstatements in the Application.** Our rights to void this contract due to misstatements in the Application are limited as follows:

- 1) For the first six months this contract is in force, we may void this contract only if we show that a misstatement is material to our decision to issue this contract.
- 2) For loss incurred after the first six months but before this contract has been in force for two years, we may void this contract only if we show that a misstatement is both material to our decision to issue this contract and related to the loss for which benefits are sought.
- 3) For losses incurred after this contract has been in force for two years, we may void this contract only if we show that you knowingly and intentionally misstated relevant facts related to your health.

If you apply for an increase in coverage under this contract, this provision will apply to the additional coverage from its effective date with regard to statements made in the application for additional coverage.

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**10. GENERAL PROVISIONS**

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(continued)

**10.5 MISSTATEMENT OF AGE.** If your age has been misstated, any amount payable will be that which the premiums paid would have bought at the correct age.

**10.6 MAINTENANCE OF SOLVENCY.** If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

**10.7 CROSS BORDER RULES.** If you receive Qualified Long-Term Care Services in a state other than the state in which this contract was issued, any state differences in care provider licensing or certification requirements will not affect your eligibility for benefits under this contract if similar services would be covered in the issue state.

**10.8 MEMBERSHIP.** You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

**10.9 ASSIGNMENT.** You may assign any benefits payable under this contract. We are not bound by the assignment unless you notify us in writing at our Service Center. Unless otherwise specified by you, the effective date of the assignment will be the date you sign the notice of assignment, except for any payments made or actions taken by us prior to our receipt of the notice. We are not responsible for the validity or effect of any assignment. You will keep all membership rights and privileges.

**10.10 DIVIDENDS.** Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend on the Contract Anniversary.

Dividends will be used to reduce premiums. Any portion of dividends not immediately used to reduce a premium due will accumulate at 3.5% interest until used to pay any future premiums. Upon termination of this contract, any remaining accumulated dividends will be paid to you, but only to the extent that they do not exceed the sum of premiums paid by you and applied to this contract. As used in this provision, the sum of premiums paid does not include premiums waived by us or reduced by dividends.

**10.11 TERMINATION.** This contract will terminate upon the earliest of the following dates:

- 1) The date of your death.
- 2) The date of your Notice to cancel this contract. The date of Notice is the date we receive it or, if later, the date you specify.
- 3) The date this contract terminates under Section 9.4 Premium in Default and Grace Period.
- 4) The date the Available Benefit is reduced to zero.

Upon termination we will:

- 1) Refund the portion of any premium you paid for the period beyond the date of termination;
- 2) Refund the retained portion of any premium you paid for any period during which premiums were waived, if any, provided that amount was not previously applied to pay another premium; and
- 3) Distribute any remaining accumulated dividends as described in Section 10.10 Dividends.

If you cancel this contract by giving us Notice, coverage ceases on the date the notice is signed, but payment for losses incurred while this contract was in force is not affected.

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**10. GENERAL PROVISIONS**

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(continued)

**10.12 EXTENSION OF BENEFITS.** If this contract terminates under Section 9.4 Premium in Default and Grace Period while you are receiving benefits under Section 3.1 Residential Care Facility Benefit, coverage will be continued until the earliest of the following dates:

- 1) The date you are no longer a resident of a Residential Care Facility.
- 2) The date of your death.
- 3) The date the Available Benefit is reduced to zero.

Coverage continued under this section will be subject to all of the conditions and limitations of this contract.

**10.13 CONFORMITY WITH STATE LAWS.** On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.





A Fraternal Benefit Society • Appleton, Wisconsin 54919-0001

## LONG-TERM CARE INSURANCE

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**This is a long-term care insurance contract with benefits  
for residential facility, home and community-based care.  
Guaranteed renewable for life.  
Premiums subject to change.  
Annual dividends payable if earned.**

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**CASH BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

Benefits paid under this rider may be subject to aggregation rules under the Internal Revenue Code Section 7702B for the purpose of Federal Income Tax calculation. If the total of benefits paid under this rider and this contract exceed the per diem limitation for that period, any benefits paid in excess of the limitation may be taxable. You are advised to consult a tax advisor.

**1. DATE OF ISSUE OF THIS RIDER.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. THE BENEFIT.** After the Elimination Period has ended, for any calendar month in which we pay benefits under Section 3 Long-Term Care Benefits of this contract for expenses incurred on at least five separate days, we will pay you:

- 1) 15% of the Maximum Monthly Benefit in effect on the last day of that calendar month if on any of those days you received benefits for care under Sections 3.3 or 3.4; otherwise
- 2) 10% of the Maximum Monthly Benefit in effect on the last day of that calendar month.

Benefits paid under this rider will not reduce the Available Benefit of this contract.

**3. TIME LIMIT ON CERTAIN DEFENSES FOR THIS RIDER.** The Time Limit on Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

**4. TERMINATION.** This rider will terminate on the earlier of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**COMPOUND 3% ANNUAL INCREASE BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DEFINITIONS.**

**Date of Issue of this Rider.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**Rider Anniversary.** The same month and day of each year after issue of this rider as in the Date of Issue of this Rider.

**2. THE BENEFIT.** This contract's Maximum Monthly Benefit, Ancillary Benefit Limits and Available Benefit will be increased on each Rider Anniversary by 3% of the corresponding amounts in effect immediately before the increase. These increases will continue without regard to your age, claim status, claim history or the length of time you have been insured under this contract.

**3. TIME LIMIT ON CERTAIN DEFENSES FOR THIS RIDER.**

The Time Limit on Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

**4. TERMINATION.** This rider will terminate on the earlier of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**COMPOUND 5% ANNUAL INCREASE BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DEFINITIONS.**

**Date of Issue of this Rider.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**Rider Anniversary.** The same month and day of each year after issue of this rider as in the Date of Issue of this Rider.

**2. THE BENEFIT.** This contract's Maximum Monthly Benefit, Ancillary Benefit Limits and Available Benefit will be increased on each Rider Anniversary by 5% of the corresponding amounts in effect immediately before the increase. These increases will continue without regard to your age, claim status, claim history or the length of time you have been insured under this contract.

**3. TIME LIMIT ON CERTAIN DEFENSES FOR THIS RIDER.**

The Time Limit on Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

**4. TERMINATION.** This rider will terminate on the earlier of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**FLEXIBLE INCREASE BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DEFINITIONS.**

**Date of Issue of this Rider.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**Rider Anniversary.** The same month and day of each year after issue of this rider as in the Date of Issue of this Rider.

**2. THE BENEFIT.** This rider provides an automatic increase in your coverage on each Rider Anniversary without regard to your age, claim status, claim history or the length of time you have been insured under this contract. We will notify you before the effective date of each increase. You may decline the increase as specified in our notice. However, if you decline three consecutive increases:

- 1) Automatic annual increases will cease; and
- 2) Future increases will be provided only on Rider Anniversaries occurring while premiums are being waived under the Waiver of Premium provision of this contract.

**3. BENEFIT INCREASES.** The Maximum Monthly Benefit and Available Benefit will increase by 5% of the benefit amounts in effect on the date of our notice. Ancillary Benefit Limits will increase accordingly. If any changes to your coverage are effective after the date of our notice but before the date of the increase, these benefit amounts will change. We will notify you of the new amounts.

The premiums for an increase in coverage under this rider will be based on your age at the time of the increase.

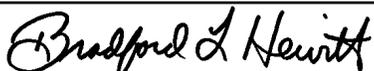
**4. TIME LIMIT ON CERTAIN DEFENSES FOR THIS RIDER.** The Time Limit on Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

**5. TERMINATION.** This rider will terminate on the earlier of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**LIMITED PREMIUM PAYMENT PERIOD CONTINGENT NONFORFEITURE BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DATE OF ISSUE OF THIS RIDER.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. BENEFIT TRIGGER.** The Limited Premium Payment Period Contingent Nonforfeiture Benefit will be triggered if:

- 1) We increase the premium payable for this contract;
- 2) The new premium represents a substantial premium increase as defined below;
- 3) Prior to the due date of the increased premium, premiums have been paid for at least 40% of the number of months in the premium payment period; and
- 4) Within 120 days after the due date of the new premium, either:
  - a) This contract terminates due to premium default; or
  - b) You give Notice to cancel this contract. The date of Notice is the date we receive it or, if later, the date you specify.

A substantial premium increase is an increase that results in a cumulative percentage increase in premiums since the Date of Issue that equals or exceeds the percentage shown below:

**TRIGGERS FOR A SUBSTANTIAL  
PREMIUM INCREASE**

<u>Issue Age</u>	<u>Percentage Increase</u>
Under 65	50%
65-80	30%
Over 80	10%

On or before the effective date of a substantial premium increase we will notify you of your option to:

- 1) Reduce the benefits provided by this contract without additional underwriting, to the extent allowed by Section 10.3 Changing Your Coverage of this contract, so the contract may be continued without an increase in premium;
- 2) Terminate this contract by Notice within 120 days after the new premium is due and thereby trigger the Limited Premium Payment Period Contingent Nonforfeiture Benefit; or
- 3) Continue this contract by paying the new premium.

We will also notify you that premium default within 120 days after the effective date of the increased premium will be deemed to be an election of the Limited Premium Payment Period Contingent Nonforfeiture Benefit.

If both the Limited Premium Payment Period Contingent Nonforfeiture Benefit and the Contingent Nonforfeiture Benefit are triggered, you may choose which benefit to receive.

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**LIMITED PREMIUM PAYMENT PERIOD CONTINGENT NONFORFEITURE BENEFIT (continued)**

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**3. THE BENEFIT.** If the Limited Premium Payment Period Contingent Nonforfeiture Benefit is triggered, your coverage will continue as paid-up coverage with reduced benefit maximums. If the benefit is triggered by premium default, the paid-up coverage will be effective on the date the grace period ends. Otherwise paid-up coverage will be effective on the date of your Notice to cancel this contract.

This contract's remaining Available Benefit, Maximum Monthly Benefit and Ancillary Benefit Limits will be reduced to amounts equal to:

- 1) Ninety percent (90%) of the amounts in effect prior to termination; multiplied by
- 2) The ratio of the number of months that premiums were paid by you and applied to this contract, divided by the number of months in the premium paying period.

Premiums paid by you do not include premiums waived by us or reduced by dividends.

Benefits will be paid subject to all of the conditions and limitations of this contract. No increases will be provided under any increase benefit rider on or after the date paid-up coverage becomes effective. All riders on this contract will terminate on the date paid-up coverage becomes effective.

The Available Benefit under the paid-up coverage may be used for all care and services covered under the terms of this contract. The Available Benefit will be reduced by the amounts that we pay under the paid-up coverage. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

**4. REINSTATEMENT.** If this rider is reinstated, any benefits paid under this rider will be treated as if they had been paid by the reinstated contract. Reinstatement of this rider is subject to the Reinstatement provision of this contract.

**5. TERMINATION.** This rider will terminate on the earliest of the following dates:

- 1) The date the premium payment period of this contract ends.
- 2) The date this contract's premium payment period changes to a lifetime premium payment period as requested by you.
- 3) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [ *Bradford L Hewitt* ]

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Secretary [ *Jeresa Rasmussen* ]

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**NONFORFEITURE BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DATE OF ISSUE OF THIS RIDER.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

2) The Available Benefit in effect immediately before the date paid-up coverage becomes effective.

**2. THE BENEFIT.** After this contract has been in force for at least three years, the termination provision of this contract will include the following provisions:

The Available Benefit under the paid-up coverage may be used for all care and services covered under the terms of this contract. The Available Benefit will be reduced by the amounts that we pay under the paid-up coverage. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

- 1) If you give Notice to cancel this contract, your coverage will continue as paid-up coverage effective the date of your Notice. Any premium paid for coverage beyond that date will be refunded to you and will not be included when calculating the Nonforfeiture Credit.
- 2) If the premium required to keep this contract in force has not been paid by the end of the grace period, your coverage will continue as paid-up coverage effective on the date the grace period ends.

**3. NONFORFEITURE CREDIT.** The Nonforfeiture Credit is equal to the greater of:

- 1) The total of all premiums paid by you and applied to this contract; and
- 2) The Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective.

If your coverage continues as paid-up coverage, no contingent nonforfeiture benefit is available under this contract.

Premiums paid by you do not include premiums waived by us or reduced by dividends.

Benefits will be paid subject to all of the conditions and limitations of this contract. No increases will be provided under any increase benefit rider on or after the date paid-up coverage becomes effective. All riders on this contract will terminate on the date paid-up coverage becomes effective.

**4. TERMINATION.** This rider will terminate on the earlier of the following dates:

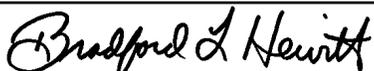
- 1) The date you give Notice to cancel this rider. The date of your Notice is the date we receive it or, if later, the date you specify. If you cancel this rider by Notice and the contract to which it is attached remains in force, no Nonforfeiture Benefit will be provided by this rider.
- 2) The date this contract terminates.

The paid-up coverage will have an Available Benefit equal to the lesser of:

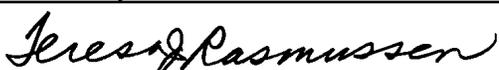
- 1) The Nonforfeiture Credit (see Section 3 below); and

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**RESTORATION OF BENEFITS**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DATE OF ISSUE OF THIS RIDER.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. THE BENEFIT.** The Available Benefit and amounts available for Ancillary Benefits will be restored if:

- 1) After receiving benefits, a Licensed Health Care Practitioner certifies that you have not been Chronically Ill for a period of 180 consecutive days; and
- 2) This contract is still in force at the end of the 180-day period.

At our expense, we may request additional information or perform an on-site assessment to confirm that you were not Chronically Ill during the 180-day period.

Benefits will be restored on the day after the 180-day period as follows:

- 1) The Available Benefit will be restored to the amount that would have been in effect had no benefits been paid.
- 2) Amounts paid for Ancillary Long-Term Care Benefits prior to that day will be disregarded when calculating new amounts payable for Ancillary Long-Term Care Benefits.

There is no limit on how often benefits paid under this contract can be restored.

**3. TIME LIMIT ON CERTAIN DEFENSES FOR THIS RIDER.** The Time Limit on Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

**4. TERMINATION.** This rider will terminate on the earlier of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**RETURN OF PREMIUM UPON DEATH**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

This benefit may have tax implications for your estate. You are advised to consult a tax advisor.

**1. DATE OF ISSUE OF THIS RIDER.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. THE BENEFIT.** After this rider has been in force for 10 years, upon your death we will pay your estate an amount equal to:

- 1) The sum of all premiums paid by you and applied to this contract;

Less

- 2) The sum of:
  - a) Any accumulated dividends paid upon death; and
  - b) The sum of any benefits paid under this contract.

The sum of premiums paid does not include premiums waived by us or reduced by dividends.

To pay the benefit under this rider, we require:

- 1) Proof of death; and
- 2) Written notice in form and content satisfactory to us from a representative of your estate that no expenses eligible for payment are outstanding.

If eligible expenses are submitted after benefits are paid under this rider, benefits for those expenses will be reduced by the amount paid under this rider.

Benefits paid under this rider will reduce the Available Benefit of this contract.

**3. TERMINATION.** This rider will terminate on the earlier of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**SHARED CARE BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the:

- 1) Application signed by the applicant;
- 2) Eligibility Requirements in Section 2 of this rider; and
- 3) Payment of premiums as shown in the Contract Schedule.

If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DEFINITIONS.**

**Benefit Partner.** The person named as your Benefit Partner in the Contract Schedule.

**Date of Issue of this Rider.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. ELIGIBILITY REQUIREMENTS.** For you to be eligible for this rider, your Benefit Partner must be issued and maintain a Long-Term Care Insurance contract that:

- 1) Has the same date of issue as the Date of Issue of this contract;
- 2) Has the same Premium Payment Period, Elimination Period, Maximum Monthly Benefit amount, Benefit Multiplier and riders as this contract; and
- 3) Includes a Shared Care Benefit rider that names you as the Benefit Partner.

**3. THE SHARING AGREEMENT.** You and your Benefit Partner have agreed to share each other's Available Benefit if one of you exhausts his or her own Available Benefit. This rider provides that if one contract's Available Benefit is reduced to \$0, that contract will not terminate if the other contract is in force with an Available Benefit greater than \$0. Instead, benefits under Section 3 Long-Term Care Benefits that would otherwise be payable from the contract with the depleted Available Benefit will:

- 1) Be paid from the other contract; and
- 2) Reduce the other contract's Available Benefit.

Other than reducing this contract's Available Benefit, payment of benefits to your Benefit Partner will not affect your eligibility for benefits under this contract.

**4. WAIVER OF PREMIUM BENEFIT.** Whenever your Benefit Partner meets the requirements for the Waiver of Premium Benefit in his or her contract, premiums for this contract will also be waived.

**5. RESIDUAL BENEFIT.** If this contract terminates as a result of your Available Benefit being reduced to \$0 solely due to payment of benefits to your Benefit Partner, you may apply to buy a continuation of this contract's coverage if you meet the following eligibility requirements:

- 1) The date of termination is before your 86<sup>th</sup> birthday;
- 2) No days have ever been credited to your Elimination Period; and
- 3) You have not been eligible to be certified as Chronically Ill any time in the two years before the date of your application.

We will notify you when the Available Benefit is reduced to \$0. To purchase continued coverage, you must apply to us at our Service Center within 60 days after the date of our notification. The new coverage will be a continuation of this contract's coverage subject to the following:

- 1) Other than to verify the eligibility requirements of this section, no underwriting will be required.

(continued)

**SHARED CARE BENEFIT**

(continued)

- 2) No Shared Care Benefit rider, Survivorship Benefit rider or Flexible Increase Benefit rider will be included.
- 3) The effective date of the new coverage will be the date this contract terminated.
- 4) The Maximum Monthly Benefit will be the same as it as was on the date this contract terminated.
- 5) The new Available Benefit will be equal to 24 times the Maximum Monthly Benefit.
- 6) Premiums for the new coverage will be based on your age last birthday on its effective date.
- 7) The Time Limit on Certain Defenses provision of this contract will apply to the new coverage for two years from its effective date with regard to statements made in the application for the coverage.

**6. BENEFIT UPON DEATH OF YOUR BENEFIT PARTNER.** If your Benefit Partner dies while this rider is in force, that person's remaining Available Benefit will be added to the Available Benefit of this contract. After the Available Benefit is added to this contract, any benefits payable for expenses incurred by your Benefit Partner prior to death will be paid from this contract's Available Benefit.

**7. REINSTATEMENT.** If this contract terminates for nonpayment of premium, this rider may be reinstated if this contract is reinstated. If this rider terminates because your Benefit Partner's contract terminates for nonpayment of premium, this rider may be reinstated if your Benefit Partner's contract is reinstated. In both cases, at the time of reinstatement of this rider, your Benefit Partner must have a Thrivent Financial for Lutherans long-term care insurance contract in force that includes a Shared Care Benefit rider that names you as the Benefit Partner.

The Time Limit on Certain Defenses provision of this contract will apply from the date this rider is reinstated with regard to any statements made in the application for reinstatement.

**8. TERMINATION.** This rider will terminate on the earliest of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The date this contract has a different Premium Payment Period, Elimination Period, Maximum Monthly Benefit amount, Benefit Multiplier or rider than that on your Benefit Partner's contract.
- 3) The date your Benefit Partner's Shared Care Benefit rider terminates.
- 4) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

President [ *Bradford L Hewitt* ]

Secretary [ *Jeres Rasmussen* ]

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**SURVIVORSHIP BENEFIT**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicants and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DEFINITIONS.**

**Benefit Partner.** The person named as your Benefit Partner in the Contract Schedule.

**Date of Issue of this Rider.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. THE BENEFIT.** Premiums for this contract will be waived for life if your Benefit Partner dies and the following conditions are met:

- 1) Your Benefit Partner is the owner of a Thrivent Financial for Lutherans long-term care insurance contract that:
  - a) Has the same date of issue as the Date of Issue of this contract; and
  - b) Includes a Survivorship Benefit rider that names you as the Benefit Partner;
- 2) On the date your Benefit Partner dies, this rider and your Benefit Partner's Survivorship Benefit rider have each been in force for at least ten years; and
- 3) Neither you nor your Benefit Partner was Chronically Ill at any time during the first ten years after the Date of Issue of this Rider.

**3. REINSTATEMENT.** If this contract terminates for nonpayment of premium, this rider may be reinstated if this contract is reinstated. If this rider terminates because your Benefit Partner's contract terminates for nonpayment of premium, this rider may be reinstated if your Benefit Partner's contract is reinstated. In both cases, at the time of reinstatement of this rider, your Benefit Partner must have a Thrivent Financial for Lutherans long-term care insurance contract in force that includes a Survivorship Benefit rider which names you as the Benefit Partner.

The Time Limit on Certain Defenses provision of this contract will apply from the date this rider is reinstated with regard to any statements made in the application for reinstatement.

**4. TERMINATION.** This rider will terminate on the earliest of the following dates:

- 1) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 2) The first day of the Elimination Period if that day is during the first ten years after the Date of Issue of this Rider.
- 3) The date your Benefit Partner's Survivorship Benefit rider terminates, unless that termination is due to your Benefit Partner's death after this rider has been in force for ten years.
- 4) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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**WAIVER OF ELIMINATION PERIOD FOR HOME CARE AND ADULT DAY CARE**

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Date of Issue of this Rider: [ September 01, 2012 ]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown in the Contract Schedule. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

**1. DATE OF ISSUE OF THIS RIDER.** Unless otherwise shown above or in the Contract Schedule, the Date of Issue of this Rider is the Date of Issue of this contract.

**2. THE BENEFIT.** Benefits provided under contract Sections 3.3 Adult Day Care Benefit and 3.4 Home Care Benefit are not subject to the Elimination Period.

**3. TIME LIMIT ON CERTAIN DEFENSES FOR THIS RIDER.** The Time Limit on Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

**4. TERMINATION.** This rider will terminate on the earliest of the following dates:

- 1) The last day of the Elimination Period.
- 2) The date of your Notice to cancel this rider. The date of Notice is the date we receive it or, if later, the date you specify.
- 3) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

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President [  ]

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Secretary [  ]

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Yes  No 3. Do you have any life insurance or annuity contracts currently in force which provide similar long-term care coverage? If yes, provide details.

Company		Contract number		
Address	City			
	State	ZIP code	Phone	
Type of coverage	Benefit/contract amount	Maximum period	Annual premium	

Yes  No Will coverage be discontinued if this Long-Term Care Insurance contract is issued?

Yes  No If yes, is this a 1035 exchange?

Reason for replacement

Yes  No 4. Did you have another long-term care, nursing home policy, contract or rider in force during the last twelve (12) months? If yes, provide details.

Company	Contract number	Coverage end date
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**Section 3 - Long-Term Care Insurance New Business Benefit Information**

Benefit Multiplier  24 months  36 months  60 months  96 months  120 months

Elimination Period  30 day  90 day  180 day

Maximum Monthly Benefit Amount \$ \_\_\_\_\_

Contract Pay Type  Lifetime Pay  10-Pay  Pay to Age 65

**Benefit Increase Options**

Annual Increase Benefit - 3% Compound

Annual Increase Benefit - 5% Compound

**Check if rejecting Annual Increase Benefit**

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this contract with and without annual increase benefit, and I reject annual increase benefit.

Signature of proposed insured and date signed (mm/dd/yyyy)

Flexible Increase Benefit

None

**Optional Riders**

Cash Benefit

Nonforfeiture Benefit

Restoration of Benefits

Return of Premium Upon Death

Shared Care Benefit

Survivorship Benefit

Waiver of Elimination Period for Home Care and Adult Day Care

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**Section 4 - Long-Term Care Insurance Contract Change**

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- Increase Benefit Multiplier to     36 months     60 months     96 months     120 months  
 Decrease Benefit Multiplier to     24 months     36 months     60 months     96 months
- 
- Increase Elimination Period to     90 day     180 day  
 Decrease Elimination Period to     30 day     90 day
- 
- Increase     Decrease    Maximum Monthly Benefit Amount to \$ \_\_\_\_\_
- 

**Optional Rider(s)**

Add	Delete	
<input type="checkbox"/>	<input type="checkbox"/>	Annual Increase Benefit - 3% Compound Increases
<input type="checkbox"/>	<input type="checkbox"/>	Annual Increase Benefit - 5% Compound Increases
<input type="checkbox"/>	<input type="checkbox"/>	Cash Benefit
<input type="checkbox"/>	<input type="checkbox"/>	Flexible Increase Benefit
	<input type="checkbox"/>	Nonforfeiture Benefit
<input type="checkbox"/>	<input type="checkbox"/>	Restoration of Benefits
	<input type="checkbox"/>	Return of Premium Upon Death
	<input type="checkbox"/>	Shared Care Benefit
	<input type="checkbox"/>	Survivorship Benefit
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Elimination Period for Home Care and Adult Day Care

- Change Contract Pay Type to Lifetime Pay  
 Add Spouse/Partner/Family Member discount - contract number - \_\_\_\_\_
- 

**Section 5 - Premium Payment Information**

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- Total initial premium \$ \_\_\_\_\_     No premium with application
- 

Premium billing amount \$ \_\_\_\_\_

Frequency  Annual     Semiannual     Quarterly     Monthly     \_\_\_\_\_

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**Section 6 - Protection Against Unintended Lapse**

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I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance contract for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

- I elect not to designate any person to receive such notice.

I request that you notify the following person:

Name (print title, first, middle, last name and suffix, as applicable)

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Address	City		
	State	ZIP code	Phone

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**Section 7 - Special Requests**

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**Section 8 - Agreement and Authorization**

**I understand and agree that:**

1. I have read all statements and answers recorded on this application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true, complete and correctly recorded.
2. The entire application consists of this Application for Individual Long-Term Care Insurance and all supplemental application forms required for the contract or change applied for as defined by the company. The entire application will become part of any contract issued or the contract for which a requested change has been approved.
3. No Representative of the company has the authority to change or waive any question contained in the application or to modify the application in any way.
4. No Representative of the company has the authority to accept risks or determine insurability for the company.
5. The date of the application is the latest of the following dates:
  - a) The date shown on the Application for Individual Long-Term Care Insurance;
  - b) The date shown on any required supplemental application forms;
  - c) The date shown on the Declaration of Insurability.
6. Any change in this application that will result in any change in plan of insurance, amount, age at issue, sex, class or benefits shall require my written consent.
7. Thrivent Financial may require an attending physician's statement, medical records, an underwriting assessment, a medical exam, a motor vehicle report, a prescription drug or medication report or other questionnaire or test.
8. I have received the following:
  - Outline of Coverage • Long-Term Care Insurance Personal Worksheet • Potential Rate Increase Disclosure Form
  - Things You Should Know Before You Buy Long-Term Care Insurance • Shopper's Guide to Long-Term Care Insurance

**In addition, for New Business:**

No insurance will take effect unless and until:

- a. A contract of insurance is issued and delivered;
- b. The first full premium is paid during the lifetime of the person to be covered; and
- c. The health of the person to be insured remains as stated in this application.

**In addition, for Contract Change:**

1. I agree that the requested change in my contract shall not become effective unless and until the required premium has been paid and the requested change has been approved by the company.
2. With regard to statements made in this application, the Time Limit on Certain Defenses provision will apply from the effective date of the contract change.

The signature below applies to all sections and statements on this application.

Signed at \_\_\_\_\_  
City State

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

**Caution: If your answers on this application are incorrect or untrue, Thrivent Financial for Lutherans may deny benefits or rescind your contract.**

Signature of proposed insured and date signed (mm/dd/yyyy)

List any other health insurance contracts that you have sold to the insured that are still in force.

--	--	--	--

List any other health insurance contracts that you have sold to the insured in the past five years that are no longer in force.

--	--	--	--

I certify that I have asked all questions and recorded all answers as they were given to me and reviewed these with the proposed insured.

To the best of my knowledge, the contract applied for  is  is not intended to replace any part of, or all of, another contract.

Signature of financial representative and date signed (mm/dd/yyyy)

Name of financial representative

Code number of financial representative

--	--

# Preliminary Declaration of Insurability Long-Term Care Insurance

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## Section 1 - Proposed Insured Information

---

Name (print title, first, middle, last name and suffix, as applicable)

---

## Section 2 - Preliminary Insurability

---

- Yes     No    1. Within the past five years, have you had, been diagnosed, been treated or taken medication for:
- |  |   |
|--|---|
| <input type="checkbox"/> Alcohol or controlled substance dependency  | <input type="checkbox"/> Huntington's Chorea  |
| <input type="checkbox"/> Alzheimer's disease, dementia, senility, organic brain syndrome, or frequent or persistent forgetfulness or memory loss | <input type="checkbox"/> Multiple Sclerosis or post-polio syndrome                          |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's disease)   | <input type="checkbox"/> Muscular Dystrophy   |
| <input type="checkbox"/> Bone marrow, Hodgkin's disease, leukemia or lymphoma disorder   | <input type="checkbox"/> Myasthenia Gravis  |
| <input type="checkbox"/> Cancer of the bone, brain, esophagus, liver, lung, kidney, ovary, pancreas, stomach, or any metastatic cancer           | <input type="checkbox"/> Organ transplant other than cornea                                 |
| <input type="checkbox"/> Cirrhosis of the liver  | <input type="checkbox"/> Paralysis (excluding Bell's palsy), paraplegia or quadriplegia     |
| <input type="checkbox"/> Cystic Fibrosis   | <input type="checkbox"/> Parkinson's disease  |
| <input type="checkbox"/> Down's syndrome   | <input type="checkbox"/> Renal failure, chronic kidney disease, not including kidney stones |
| <input type="checkbox"/> Emphysema or other lung disorder requiring the use of oxygen  | <input type="checkbox"/> Schizophrenia or other forms of psychosis                          |
|  | <input type="checkbox"/> Stroke   |
|  | <input type="checkbox"/> Transient Ischemic Attack (TIA)                                    |
- 

- Yes     No    2. Have you ever tested positive for exposure to Human Immunodeficiency Virus (HIV) infection, been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?
- 

- Yes     No    3. During the last 12 months, have you used:
- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Catheter          | <input type="checkbox"/> Quad cane  |
| <input type="checkbox"/> Chairlift         | <input type="checkbox"/> Respirator |
| <input type="checkbox"/> Dialysis          | <input type="checkbox"/> Stair lift |
| <input type="checkbox"/> Hospital bed      | <input type="checkbox"/> Walker     |
| <input type="checkbox"/> Motorized scooter | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Oxygen equipment  |                                     |
- 

- Yes     No    4. Do you currently or within the past 12 months have you ever required assistance or supervision of any kind to perform any of the following activities:
- |   |   |
|---|---|
| <input type="checkbox"/> Bathing                  | <input type="checkbox"/> Moving in or out of bed or chair |
| <input type="checkbox"/> Bowel or Bladder Control | <input type="checkbox"/> Taking your medication           |
| <input type="checkbox"/> Dressing                 | <input type="checkbox"/> Toileting                        |
| <input type="checkbox"/> Eating                   | <input type="checkbox"/> Walking                          |
-



# Declaration of Insurability Long-Term Care Insurance

**Section 1 - Proposed Insured Information**

Name (print title, first, middle, last name and suffix, as applicable)

**Section 2 - Declaration of Insurability**

Height - \_\_\_ Ft \_\_\_ In

Weight - \_\_\_\_\_ Lbs

Weight 1 year ago - \_\_\_\_\_ Lbs

Name of primary health care provider for the past two years - Indicate if none.

Date last consulted	Reason last consulted	
Type of treatment	Medication prescribed	Recovery date

**Place details for all "Yes" answers for questions 1-6 in Section 3.**

1. Within the past 10 years, have you had, been diagnosed or been treated by a physician or other member of the medical profession, chiropractor, counselor or any other health care provider for any of the following:

- |                          |                          |                          |                          |  |   |
|--------------------------|--------------------------|--------------------------|--------------------------|--|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (a) disease or disorder of the heart, circulatory, blood or immune system (excluding Human Immunodeficiency Virus (HIV))?<br>If high blood pressure:<br>Last blood pressure reading - ____ / ____ Date of last blood pressure reading - _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (b) abnormal growth, cyst, tumor or cancer?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (c) disease or disorder of the respiratory system?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (d) disease or disorder of the digestive system (e.g., stomach, intestines, rectum, liver, gallbladder, esophagus)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (e) disease or disorder of the urinary system, (e.g., kidneys, bladder)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (f) disease or disorder of the endocrine/hormone system (e.g., diabetes)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (g) disease or disorder of the nervous system, including psychological and psychiatric care?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (h) disease or disorder of the muscle, skin, bone or joint?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (i) disease or disorder of the reproductive system?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (j) disease or disorder of the eyes, ears, nose or throat?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | 2. Within the past 10 years have you received medical treatment or counseling for, or been advised by a physician or other member of the medical profession, chiropractor, counselor or any other health care provider to discontinue the use of alcohol or controlled substances or been a member of Alcoholics Anonymous, Narcotics Anonymous, or other support organization? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | 3. Within the past 10 years, have you used or are you currently using, except as prescribed by a physician, controlled substances such as cocaine, marijuana, amphetamines or narcotics?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | 4. Other than reported above, within the past five years, have you:   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (a) consulted or been advised to consult a physician or other member of the medical profession, chiropractor, psychiatrist, psychologist, or counselor for any reason?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (b) been advised to have surgery, medical evaluation or other diagnostic test(s) other than an AIDS related test that has not yet been completed?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (c) been advised by a physician, or other member of the medical profession, chiropractor or medical therapist to restrict or avoid normal activities due to illness or injury?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | (d) taken any other prescription drugs?   |

Prescription Drug Used	Date Last Used	Reason for Use

Yes     No    5. Within the past five years, have you been diagnosed or treated by a physician or other member of the medical profession, chiropractor, counselor, or any other health care provider for multiple falls or any fall that resulted in a fracture?

Yes     No    6. Other than reported above, within the past five years, have you been under the care of a physician or other member of the medical profession or are you scheduled to see a physician or other member of the medical profession?

Yes     No    7. Do you currently use, or within the past 10 years have you used, tobacco or other nicotine products?

Type of Tobacco/Nicotine Product	Date Last Used

Yes     No    8. Within the past two years have you been required or advised by a physician or other member of the medical profession, chiropractor, counselor or any other health care provider to have nursing home care or home health care?

Reason Care Needed	Date Began	Date Ended

Yes     No    9. Have your biological parents, brothers, or sisters been diagnosed or treated by a physician or other member of the medical profession, chiropractor, counselor or any other health care provider for Alzheimer's disease, cancer (internal or melanoma), coronary artery disease, diabetes, or Huntington's disease?

Disease or Disorder	Relationship to Proposed Insured	Age at Onset	Current Age	Age at Death

Yes     No    10. Do you currently drive?    If yes, miles per year - \_\_\_\_\_

Yes     No    11. Within the past five years, have you had a driver's license suspended or had a moving traffic violation?



Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Yes  No 16. Within the past five years, have you made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition? If yes:

Type of injury, sickness, disability, or impaired condition

Claim begin date (mm/yyyy)

Claim end date (mm/yyyy)

Name of treating health care provider

**Section 3 - Details for questions answered "Yes"**

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance	Date of diagnosis	
Date of onset	Number of occurrences	Treatment	Number of times treated
Last occurrence date	Time lost from work/school	Recovered <input type="checkbox"/> Yes <input type="checkbox"/> No	Recovery date Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking
Residuals	Care provider/Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance	Date of diagnosis	
Date of onset	Number of occurrences	Treatment	Number of times treated
Last occurrence date	Time lost from work/school	Recovered <input type="checkbox"/> Yes <input type="checkbox"/> No	Recovery date Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking
Residuals	Care provider/Facility with records if other than primary care provider		





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# Supplement to Declaration of Insurability Long-Term Care Insurance

## Aid, Appliance or Assistance Details - Continuation

Name of proposed insured (print title, first, middle, last name and suffix, as applicable)

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

Aid, appliance or assistance needed

Reason needed

Date began

Current use

Yes  No

Date ended

---

Aid, appliance or assistance needed

---

Reason needed

---

Date began

Current use

Date ended

Yes     No

---

Aid, appliance or assistance needed

---

Reason needed

---

Date began

Current use

Date ended

Yes     No

---

Aid, appliance or assistance needed

---

Reason needed

---

Date began

Current use

Date ended

Yes     No

---

Aid, appliance or assistance needed

---

Reason needed

---

Date began

Current use

Date ended

Yes     No

---

Aid, appliance or assistance needed

---

Reason needed

---

Date began

Current use

Date ended

Yes     No

---

I have read the statements and answers recorded on this Supplement to Declaration of Insurability. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Declaration of Insurability.

Signed at \_\_\_\_\_

City

State

---

Signature of proposed insured and date signed (mm/dd/yyyy)

---

Signature of representative and date signed (mm/dd/yyyy)

---

## Residual Benefit Declaration of Insurability for Individual Long-Term Care Insurance

Thrivent ID
Contract number

### Section 1 - Proposed Insured Information

Name (print title, first, middle, last name and suffix, as applicable)

Address	City		
	State	ZIP code	Phone

### Section 2 - Chronically III

**Chronically III** is defined as: On any given day, you are Chronically III if a Licensed Health Care Practitioner has, within the 12-month period preceding that day, certified that you have:

1. A Physical Impairment that is expected to last at least 90 days; or
2. A Cognitive Impairment.

A **Physical Impairment** is an impairment that prevents you from performing two or more of the following Activities of Daily Living without the Substantial Assistance of another person:

1. **Bathing.** Washing oneself in a tub or shower, including getting in or out of the tub or shower, or by sponge bath.
2. **Contenance.** Maintaining control of bowel and bladder function or, if unable to do so, taking care of the personal hygiene associated with incontinence, including caring for a catheter or colostomy bag.
3. **Dressing.** Putting on and taking off all items of clothing and any necessary braces, fasteners or prostheses.
4. **Eating.** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or, if necessary, by feeding tube or intravenously. Eating does not include preparing meals.
5. **Transferring.** Moving into or out of a bed, chair or wheelchair.
6. **Using the Toilet.** Getting to and from the toilet, transferring on and off the toilet and performing the associated personal hygiene.

When a Licensed Health Care Practitioner has certified that you are unable to perform Activities of Daily Living for an expected period of at least 90 days due to a Physical Impairment and you are receiving Qualified Long-Term Care Services, the certification may not be rescinded and additional certifications may not be performed until after the 90-day period.

**Substantial Assistance** means hands-on assistance or standby assistance. Hands-on assistance is the physical assistance of another person without which one would not be able to perform an Activity of Daily Living. Standby assistance is the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to oneself while performing an Activity of Daily Living.

A **Cognitive Impairment** is an impairment of the mind that:

1. Is comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia;
2. Is measured by clinical evidence and standardized tests that reliably measure impairment in your short-term or long-term memory, orientation as to person, place or time, deductive or abstract reasoning, and judgment as to safety awareness; and
3. Results in the need for continual supervision (which may include cuing by verbal prompting, gestures or other demonstrations) by another person to protect you from threats to your health or safety (such as may result from wandering).



# Application Change

Name of proposed insured(s)	Date of application	Contract number
-----------------------------	---------------------	-----------------

I change my application with Thrivent Financial for Lutherans as follows:

I hereby agree that this form is a part of the original application and shall be binding on any person who shall have or claim any interest in any contract issued on the basis of such application. I hereby agree that all representations made are true and complete to the best of my knowledge and belief on the date signed.

Dated at \_\_\_\_\_ City, State \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Insured (age 16 or over) Parent or guardian (if Proposed Insured is age 0-15)	Print name of Proposed Insured (age 16 or over) Parent or guardian (if Proposed Insured is age 0-15)
Signature of Other Proposed Insured	Print name of Other Proposed Insured
Signature of applicant controller	Print name of applicant controller
Signature of owner	Print name of owner
Signature of owner	Print name of owner
Signature of owner	Print name of owner

SERFF Tracking #:

THRV-128572645

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name: Long-Term Care (2012)

Project Name/Number: /

### Rate Information

Rate data applies to filing.

Filing Method: SERFF

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: 0.000%

Effective Date of Last Rate Revision:

Filing Method of Last Filing: N/A

### Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Thrivent Financial for Lutherans	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

**SERFF Tracking #:**

THR-128572645

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Thrivent Financial for Lutherans

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.004 Partnership

**Product Name:**

Long-Term Care (2012)

**Project Name/Number:**

/

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information	Attachments
1	Approved 08/15/2012	Rate Schedules	H-HL-LTC (12), HR-HS-SC (12), HR-HT-CAIB3 (12), HR-HV-CAIB5 (12), HR-HC-CB (12), HR-HF-FIB (12), HR-HN-NF (12), HR-HE-WEP (12), HR-HU-SU (12), HR-HR-RB (12), HR-HP-RP (12)	New		LTC Rate Schedules.pdf

**Form H-HL-LTC (12)**  
**Long-Term Care Insurance Base Rates**  
**Maximum Monthly Benefit: \$1**  
**Premium Payment Period: Lifetime**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
18	0.11	0.13	0.18	0.21	0.23
19	0.11	0.13	0.18	0.21	0.23
20	0.11	0.13	0.18	0.21	0.23
21	0.11	0.13	0.18	0.21	0.23
22	0.11	0.13	0.18	0.21	0.23
23	0.11	0.13	0.18	0.21	0.23
24	0.11	0.13	0.18	0.21	0.23
25	0.12	0.14	0.19	0.22	0.24
26	0.12	0.14	0.19	0.22	0.24
27	0.12	0.14	0.19	0.22	0.24
28	0.12	0.14	0.19	0.22	0.24
29	0.12	0.14	0.19	0.22	0.24
30	0.12	0.14	0.19	0.22	0.24
31	0.12	0.14	0.19	0.22	0.24
32	0.12	0.14	0.19	0.22	0.24
33	0.12	0.14	0.19	0.22	0.24
34	0.12	0.14	0.19	0.22	0.24
35	0.13	0.15	0.20	0.23	0.25
36	0.13	0.15	0.20	0.23	0.25
37	0.13	0.15	0.20	0.23	0.25
38	0.13	0.15	0.20	0.23	0.25
39	0.13	0.15	0.20	0.23	0.25
40	0.13	0.15	0.20	0.23	0.25
41	0.13	0.15	0.20	0.23	0.25
42	0.13	0.15	0.20	0.23	0.25
43	0.14	0.15	0.20	0.23	0.25
44	0.14	0.15	0.21	0.23	0.25
45	0.15	0.17	0.21	0.24	0.25
46	0.15	0.17	0.22	0.25	0.26
47	0.15	0.18	0.23	0.28	0.29
48	0.17	0.19	0.25	0.29	0.31
49	0.17	0.20	0.26	0.31	0.33
50	0.18	0.21	0.28	0.33	0.35
51	0.19	0.22	0.29	0.35	0.37

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**Form H-HL-LTC (12)**  
**Long-Term Care Insurance Base Rates**  
**Maximum Monthly Benefit: \$1**  
**Premium Payment Period: Lifetime**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
52	0.19	0.23	0.31	0.37	0.41
53	0.20	0.24	0.32	0.40	0.43
54	0.21	0.25	0.34	0.42	0.46
55	0.21	0.28	0.35	0.44	0.48
56	0.22	0.29	0.37	0.47	0.52
57	0.23	0.30	0.40	0.50	0.54
58	0.24	0.32	0.42	0.52	0.57
59	0.26	0.33	0.44	0.55	0.61
60	0.28	0.35	0.46	0.58	0.64
61	0.30	0.37	0.50	0.62	0.67
62	0.31	0.40	0.52	0.66	0.72
63	0.34	0.43	0.56	0.70	0.76
64	0.36	0.46	0.59	0.75	0.80
65	0.40	0.50	0.64	0.80	0.86
66	0.43	0.53	0.69	0.86	0.92
67	0.46	0.58	0.75	0.94	0.99
68	0.51	0.63	0.81	1.01	1.07
69	0.55	0.69	0.89	1.10	1.17
70	0.61	0.76	0.98	1.20	1.27
71	0.66	0.84	1.08	1.31	1.39
72	0.73	0.92	1.18	1.44	1.52
73	0.80	1.02	1.30	1.58	1.67
74	0.88	1.12	1.44	1.75	1.85
75	0.98	1.25	1.58	1.93	2.05
76	1.08	1.39	1.76	2.12	2.27
77	1.18	1.54	1.95	2.35	2.52
78	1.30	1.71	2.15	2.60	2.79
79	1.43	1.89	2.38	2.87	3.11
80	1.57	2.09	2.63	3.18	3.45
81	1.76	2.37	2.98	3.60	3.93
82	1.95	2.64	3.33	4.02	4.40
83	2.13	2.92	3.69	4.43	4.87
84	2.32	3.19	4.04	4.85	5.35
85	2.53	3.49	4.37	5.25	5.83

Thrivent Financial for Lutherans  
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Appleton, WI 54919

**Form H-HL-LTC (12)**  
**Premium Payment Period: 10 Pay**  
**Factors Applied to Base Rates**

<b>Issue Age</b>	
<b>18</b>	3.85
<b>19</b>	3.85
<b>20</b>	3.85
<b>21</b>	3.84
<b>22</b>	3.83
<b>23</b>	3.82
<b>24</b>	3.81
<b>25</b>	3.80
<b>26</b>	3.78
<b>27</b>	3.77
<b>28</b>	3.76
<b>29</b>	3.75
<b>30</b>	3.74
<b>31</b>	3.71
<b>32</b>	3.67
<b>33</b>	3.64
<b>34</b>	3.61
<b>35</b>	3.58
<b>36</b>	3.54
<b>37</b>	3.51
<b>38</b>	3.48
<b>39</b>	3.44
<b>40</b>	3.41
<b>41</b>	3.38
<b>42</b>	3.33
<b>43</b>	3.30
<b>44</b>	3.26
<b>45</b>	3.22
<b>46</b>	3.18
<b>47</b>	3.15
<b>48</b>	3.10
<b>49</b>	3.07
<b>50</b>	3.03
<b>51</b>	2.97

<b>Issue Age</b>	
<b>52</b>	2.92
<b>53</b>	2.86
<b>54</b>	2.81
<b>55</b>	2.75
<b>56</b>	2.70
<b>57</b>	2.64
<b>58</b>	2.59
<b>59</b>	2.53
<b>60</b>	2.48
<b>61</b>	2.43
<b>62</b>	2.38
<b>63</b>	2.33
<b>64</b>	2.28
<b>65</b>	2.23
<b>66</b>	2.18
<b>67</b>	2.13
<b>68</b>	2.08
<b>69</b>	2.04
<b>70</b>	1.98
<b>71</b>	1.93
<b>72</b>	1.87
<b>73</b>	1.82
<b>74</b>	1.76
<b>75</b>	1.71
<b>76</b>	1.65
<b>77</b>	1.60
<b>78</b>	1.54
<b>79</b>	1.49

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Appleton, WI 54919

**Form H-HL-LTC (12)**  
**Premium Payment Period: Pay to Age 65**  
**Factors Applied to Base Rates**

<b>Issue Age</b>	
<b>18</b>	1.38
<b>19</b>	1.38
<b>20</b>	1.38
<b>21</b>	1.39
<b>22</b>	1.40
<b>23</b>	1.41
<b>24</b>	1.42
<b>25</b>	1.43
<b>26</b>	1.44
<b>27</b>	1.45
<b>28</b>	1.46
<b>29</b>	1.47
<b>30</b>	1.49
<b>31</b>	1.51
<b>32</b>	1.52
<b>33</b>	1.54
<b>34</b>	1.55
<b>35</b>	1.57
<b>36</b>	1.58
<b>37</b>	1.61
<b>38</b>	1.62
<b>39</b>	1.64
<b>40</b>	1.65
<b>41</b>	1.69
<b>42</b>	1.74
<b>43</b>	1.78
<b>44</b>	1.83
<b>45</b>	1.87
<b>46</b>	1.91
<b>47</b>	1.96
<b>48</b>	2.00
<b>49</b>	2.05
<b>50</b>	2.09
<b>51</b>	2.22

<b>Issue Age</b>	
<b>52</b>	2.35
<b>53</b>	2.49
<b>54</b>	2.62
<b>55</b>	2.75

**Form HR-HF-FIB (12)**  
**Flexible Increase Benefit Rider**  
**Factors Applied to Base Rates**

<b>Issue Age</b>	
<b>All</b>	1.10

Thrivent Financial for Lutherans  
4321 North Ballard Road  
Appleton, WI 54919

**Form HR-HS-SC (12)  
Shared Care Benefit Rider  
Factors Applied to Base Rates**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
All	1.33	1.25	1.16	1.10	1.08

**Form H-HL-LTC (12)  
Other Policy Options  
Factors Applied to Base Rates**

Spouse Discount - One Insured	0.850
Spouse Discount - Two Insureds	0.650
Preferred Rate Class	0.900
Standard Rate Class	1.000
Substandard 1 Rate Class	1.250
Substandard 2 Rate Class	1.500
Elimination Period: 30 days	1.200
Elimination Period: 90 days	1.000
Elimination Period: 180 days	0.900
Annual Premium Modal Load	1.000
Semiannual Premium Modal Load	1.030
Quarterly Premium Modal Load	1.048
Monthly Premium Modal Load	1.050

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**Form HR-HT-CAIB3 (12)**  
**Compound 3% Annual Increase Benefit Rider**  
**Factors Applied to Base Rates**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
18	2.30	2.33	2.25	2.32	2.29
19	2.30	2.33	2.25	2.32	2.29
20	2.30	2.33	2.25	2.32	2.29
21	2.30	2.33	2.25	2.32	2.29
22	2.30	2.33	2.25	2.32	2.29
23	2.30	2.42	2.31	2.37	2.33
24	2.30	2.42	2.31	2.37	2.33
25	2.18	2.23	2.18	2.25	2.23
26	2.18	2.23	2.18	2.25	2.23
27	2.18	2.23	2.18	2.25	2.23
28	2.18	2.31	2.24	2.30	2.27
29	2.18	2.31	2.24	2.30	2.27
30	2.18	2.31	2.24	2.30	2.27
31	2.18	2.31	2.29	2.35	2.32
32	2.18	2.38	2.29	2.35	2.36
33	2.27	2.38	2.35	2.40	2.36
34	2.27	2.46	2.35	2.45	2.41
35	2.08	2.29	2.28	2.38	2.35
36	2.08	2.29	2.28	2.38	2.39
37	2.08	2.36	2.33	2.43	2.43
38	2.17	2.36	2.33	2.48	2.43
39	2.17	2.43	2.39	2.48	2.48
40	2.17	2.43	2.39	2.52	2.52
41	2.17	2.50	2.44	2.57	2.57
42	2.25	2.57	2.56	2.67	2.61
43	2.08	2.57	2.61	2.71	2.65
44	2.15	2.64	2.53	2.81	2.70
45	2.07	2.53	2.63	2.73	2.78
46	2.14	2.60	2.55	2.70	2.71
47	2.14	2.50	2.48	2.52	2.58
48	2.07	2.41	2.30	2.50	2.43
49	2.13	2.33	2.29	2.36	2.33
50	2.06	2.26	2.24	2.27	2.25
51	2.00	2.20	2.19	2.19	2.18

Thrivent Financial for Lutherans  
4321 North Ballard Road  
Appleton, WI 54919

**Form HR-HT-CAIB3 (12)**  
**Compound 3% Annual Increase Benefit Rider**  
**Factors Applied to Base Rates**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
52	2.06	2.14	2.11	2.12	2.05
53	2.00	2.14	2.07	2.06	2.00
54	1.95	2.09	2.00	2.00	1.93
55	2.05	2.00	2.00	1.95	1.89
56	2.00	1.96	1.94	1.86	1.83
57	2.00	1.96	1.89	1.84	1.82
58	1.95	1.90	1.87	1.83	1.77
59	1.88	1.90	1.85	1.78	1.75
60	1.88	1.88	1.83	1.75	1.72
61	1.81	1.85	1.80	1.73	1.70
62	1.86	1.83	1.79	1.68	1.68
63	1.74	1.77	1.75	1.66	1.67
64	1.73	1.74	1.74	1.65	1.66
65	1.67	1.71	1.71	1.62	1.64
66	1.64	1.71	1.67	1.60	1.61
67	1.60	1.64	1.63	1.55	1.59
68	1.54	1.63	1.59	1.53	1.57
69	1.52	1.57	1.56	1.50	1.53
70	1.47	1.54	1.52	1.47	1.50
71	1.43	1.49	1.47	1.44	1.47
72	1.39	1.45	1.45	1.40	1.43
73	1.36	1.41	1.41	1.37	1.40
74	1.33	1.37	1.36	1.33	1.36
75	1.28	1.32	1.33	1.30	1.32
76	1.24	1.29	1.29	1.27	1.28
77	1.23	1.25	1.25	1.23	1.24
78	1.20	1.21	1.22	1.20	1.21
79	1.17	1.17	1.19	1.18	1.17
80	1.15	1.15	1.15	1.15	1.14
81	1.12	1.12	1.12	1.11	1.10
82	1.10	1.09	1.09	1.09	1.07
83	1.08	1.07	1.07	1.07	1.05
84	1.06	1.06	1.05	1.05	1.03
85	1.05	1.03	1.04	1.04	1.01

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**Form HR-HV-CAIB5 (12)**  
**Compound 5% Annual Increase Benefit Rider**  
**Factors Applied to Base Rates**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
18	6.30	6.83	6.50	6.58	6.43
19	6.30	6.83	6.50	6.58	6.43
20	6.30	6.83	6.50	6.58	6.43
21	6.30	6.83	6.50	6.58	6.43
22	6.30	6.83	6.50	6.58	6.43
23	6.30	6.83	6.50	6.58	6.43
24	6.30	6.83	6.50	6.58	6.43
25	5.73	6.31	6.12	6.25	6.14
26	5.73	6.31	6.12	6.25	6.14
27	5.73	6.31	6.12	6.25	6.14
28	5.73	6.31	6.12	6.25	6.14
29	5.73	6.31	6.12	6.25	6.14
30	5.73	6.31	6.12	6.25	6.14
31	5.73	6.31	6.12	6.25	6.14
32	5.73	6.31	6.12	6.25	6.14
33	5.73	6.31	6.12	6.25	6.14
34	5.73	6.31	6.12	6.25	6.14
35	5.25	5.86	5.78	5.95	5.87
36	5.25	5.86	5.78	5.95	5.87
37	5.25	5.86	5.78	5.95	5.87
38	5.25	5.86	5.78	5.95	5.87
39	5.25	5.86	5.78	5.95	5.87
40	5.25	5.86	5.78	5.95	5.87
41	5.25	5.86	5.78	6.00	6.00
42	5.25	5.86	5.78	6.10	6.09
43	4.85	5.86	5.78	6.14	6.13
44	4.85	5.86	5.47	6.19	6.22
45	4.50	5.47	5.47	5.91	6.22
46	4.50	5.47	5.20	5.70	6.00
47	4.50	5.13	4.95	5.28	5.54
48	4.20	4.82	4.52	5.08	5.18
49	4.20	4.56	4.33	4.75	4.83
50	4.00	4.37	4.20	4.47	4.53
51	3.82	4.20	4.08	4.22	4.26

Thrivent Financial for Lutherans  
4321 North Ballard Road  
Appleton, WI 54919

**Form HR-HV-CAIB5 (12)**  
**Compound 5% Annual Increase Benefit Rider**  
**Factors Applied to Base Rates**

Issue Age	Benefit Multiplier				
	24	36	60	96	120
52	3.82	4.05	3.86	4.00	3.95
53	3.67	3.91	3.76	3.81	3.74
54	3.53	3.78	3.58	3.66	3.50
55	3.58	3.52	3.53	3.53	3.39
56	3.45	3.46	3.38	3.33	3.21
57	3.38	3.41	3.25	3.24	3.12
58	3.27	3.21	3.13	3.17	3.00
59	3.08	3.20	3.05	3.04	2.89
60	3.04	3.06	2.98	2.94	2.81
61	2.89	2.97	2.84	2.88	2.75
62	2.89	2.89	2.81	2.77	2.66
63	2.68	2.74	2.67	2.69	2.59
64	2.61	2.64	2.61	2.62	2.56
65	2.50	2.56	2.53	2.53	2.50
66	2.38	2.50	2.43	2.47	2.43
67	2.33	2.38	2.34	2.38	2.38
68	2.22	2.32	2.26	2.30	2.32
69	2.14	2.19	2.16	2.23	2.24
70	2.05	2.12	2.08	2.16	2.17
71	1.98	2.03	2.00	2.08	2.10
72	1.91	1.95	1.93	2.00	2.03
73	1.84	1.87	1.87	1.92	1.95
74	1.78	1.81	1.79	1.85	1.88
75	1.70	1.73	1.74	1.78	1.80
76	1.64	1.67	1.68	1.72	1.72
77	1.61	1.61	1.63	1.64	1.65
78	1.56	1.56	1.59	1.58	1.58
79	1.52	1.51	1.55	1.52	1.51
80	1.48	1.47	1.51	1.46	1.44
81	1.43	1.40	1.44	1.39	1.36
82	1.38	1.35	1.39	1.32	1.29
83	1.35	1.31	1.35	1.27	1.24
84	1.32	1.28	1.32	1.23	1.19
85	1.28	1.25	1.30	1.20	1.15

Thrivent Financial for Lutherans  
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Appleton, WI 54919

**Form HR-HC-CB (12)**  
**Cash Benefit Rider**  
**% Load**

<b>Issue Age</b>	
<b>All</b>	16.0%

**Form HR-HN-NF (12)**  
**Nonforfeiture Benefit Rider**  
**% Load**

<b>Issue Age</b>	
<b>All</b>	8.0%

**Form HR-HE-WEP (12)**  
**Waiver of Elimination Period for Home Care and Adult Day Care Rider**  
**% Load**

<b>Issue Age</b>	
<b>All</b>	7.0%

**Form HR-HU-SU (12)**  
**Survivorship Benefit Rider**  
**% Load**

<b>Issue Age</b>	
<b>All</b>	7.0%

**Form HR-HR-RB (12)**  
**Restoration of Benefits Rider**  
**% Load**

<b>Issue Age</b>	<b>Benefit Multiplier</b>				
	<b>24</b>	<b>36</b>	<b>60</b>	<b>96</b>	<b>120</b>
<b>All</b>	10.0%	8.0%	6.0%	6.0%	6.0%

Thrivent Financial for Lutherans  
 4321 North Ballard Road  
 Appleton, WI 54919

**Form HR-HP-RP (12)**  
**Return of Premium upon Death Rider**  
**% Load**

<b>Issue Age</b>	
18	125.0%
19	125.0%
20	125.0%
21	125.0%
22	125.0%
23	125.0%
24	125.0%
25	125.0%
26	125.0%
27	125.0%
28	125.0%
29	125.0%
30	125.0%
31	125.0%
32	125.0%
33	125.0%
34	125.0%
35	125.0%
36	125.0%
37	125.0%
38	125.0%
39	125.0%
40	125.0%
41	125.0%
42	125.0%
43	125.0%
44	125.0%
45	125.0%
46	125.0%
47	125.0%
48	125.0%
49	125.0%
50	125.0%
51	126.0%

<b>Issue Age</b>	
52	128.0%
53	129.0%
54	131.0%
55	132.0%
56	134.0%
57	135.0%
58	137.0%
59	138.0%
60	140.0%
61	142.0%
62	144.0%
63	146.0%
64	147.0%
65	149.0%
66	151.0%
67	153.0%
68	155.0%
69	156.0%
70	160.0%
71	162.0%
72	163.0%
73	165.0%
74	167.0%
75	168.0%
76	170.0%
77	172.0%
78	173.0%
79	175.0%
80	177.0%
81	179.0%
82	180.0%
83	182.0%
84	184.0%
85	186.0%

The premium rate schedules are those to which the information in the actuarial memorandum applies.

Thrivent Financial for Lutherans  
4321 North Ballard Road  
Appleton, WI 54919

**Calculation Example: Issue Age 58, Benefit Multiplier = 60**

	Included?	
<b>1 Determine Base Premium</b>		
Determine Base Rate		0.42
Maximum Monthly Benefit		4,000
Limited Pay Factor for Lifetime Pay	No	1.00
Shared Care Rider Factor for No Shared Care	No	1.00
3% Compound AIB factor	No	1.00
5% Compound AIB factor	No	1.00
Flexible Increase Benefit Factor	Yes	1.10
Elimination Period Factor	90 days	1.00
Spouse Discount Factor	One-Insured	0.85
UW Class Factor	Preferred	0.90
Modal Factor	Annual	1.00
Base Premium = Product of factors		1,413.72
<b>2 Add on other rider premiums (base premium * load)</b>		
Cash Benefit Rider load for No	No	0
Nonforfeiture Benefit Rider Load for Yes	Yes	113.10
Waiver of HC EP load for Yes	Yes	98.96
Survivorship Rider load for No	No	0
Resoration of Benefits load for No	No	0
Return of Premium Rider load for No	No	0
Total Premium = Base Premium plus Riders		1,625.78

SERFF Tracking #:

THRV-128572645

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Thrivent Financial for Lutherans

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name: Long-Term Care (2012)

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	08/15/2012
Comments:			
Attachment(s):			
AR LTC Flesch Ctf.pdf AR LTC Rule & Reg 19 Ctf.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	08/15/2012
Comments:	Applications attached to Form Schedule.		
		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	08/15/2012
Comments:	Attached is Long-Term Care Insurance Outline of Coverage, form 27160 N1-12.		
Attachment(s):			
Outline 27160 N1-12.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Long-Term Care Insurance Personal Worksheet	Approved	08/15/2012
Comments:	Attached is Long-Term Care Insurance Personal Worksheet, form 27156 N1-12.		
The following items have been bracketed to indicate that the information may be subject to change:			
<ol style="list-style-type: none"> <li>1. Additional Rate Increase History will be added if any rate increases occur in the future.</li> <li>2. Year will be the year of the national average annual cost of care used.</li> <li>3. Figures will be based on the national average annual cost of care.</li> </ol>			
Attachment(s):			

SERFF Tracking #:

THRV-128572645

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company: Thrivent Financial for Lutherans

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.004 Partnership

Product Name: Long-Term Care (2012)

Project Name/Number: /

Personal Worksheet 27156 N1-12.pdf

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved	09/21/2012
Comments:	Attached are the following: 1) A Statement of Variability for the contract, riders, and application. 2) A Statement of Variability for Application Change form 20887A N1-12.		
Attachment(s):			
AR LTC SOV.pdf Application Change SOV.pdf			

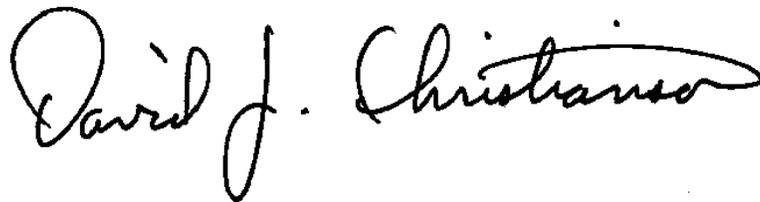
		Item Status:	Status Date:
Satisfied - Item:	Issuer Certification Form for Qualified Partnership Policies	Approved	08/15/2012
Comments:			
Attachment(s):			
AR Issuer Certification.pdf			

ARKANSAS

Certification

I, David J. Christianson, an officer of Thrivent Financial for Lutherans, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms comply with the requirements of Arkansas Code Ann. 23-80-206.

<u>Form</u>	<u>Flesch Score</u>
H-HL-LTC (12)	51
HR-HC-CB (12)	57
HR-HT-CAIB3 (12)	59
HR-HV-CAIB5 (12)	59
HR-HF-FIB (12)	59
HR-HL-LCNF (12)	50
HR-HN-NF (12)	51
HR-HR-RB (12)	58
HR-HP-RP (12)	59
HR-HS-SC (12)	55
HR-HU-SU (12)	55
HR-HE-WEP (12)	60
27154 N1-12	53
27253 N1-12	52
27158 N1-12	59
27159 N1-12	70
27507 N1-12	53
20887A N1-12	57



7/26/2012

Date

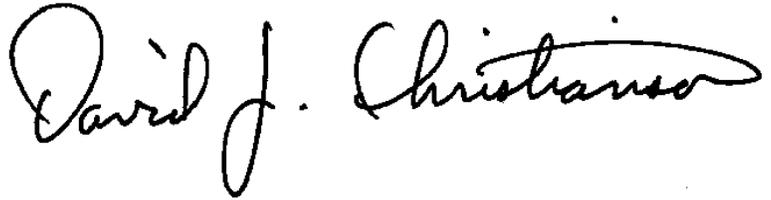
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David J. Christianson  
Director, Contract Forms and Compliance

ARKANSAS

CERTIFICATION OF ARKANSAS INSURANCE RULE AND REGULATION 19

I certify, to the best of my knowledge and belief, that this filing meets the provisions of Arkansas Insurance Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

A handwritten signature in black ink that reads "David J. Christianson". The signature is written in a cursive style with a large initial "D" and a long horizontal flourish at the end.

---

David J. Christianson, FSA, MAAA, CLU  
Director, Contract Forms and Compliance  
Product and Solutions Management

Date: 7/26/2012

## Long-Term Care Insurance Outline of Coverage Form H-HL-LTC (12)

### **CAUTION:**

The issuance of this long-term care insurance contract is based upon your responses to the questions on your application. A copy of your application will be attached to any issued contract. If your answers are incorrect or untrue, Thrivent Financial for Lutherans (called we, us and our in this outline) has the right to deny benefits or rescind your contract. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at 4321 North Ballard Road, Appleton, Wisconsin 54919-0001.

### **NOTICE TO BUYER**

This contract may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all contract limitations.

1. This contract is an individual contract of insurance.

### **2. PURPOSE OF THE OUTLINE OF COVERAGE.**

This outline of coverage provides a very brief description of the important features of the contract. You should compare this outline of coverage to outlines of coverage for other contracts available to you. This is not an insurance contract but only a summary of coverage. Only the individual contract contains governing contractual provisions. This means that the contract sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CONTRACT CAREFULLY!**

### **3. FEDERAL TAX CONSEQUENCES.**

This contract is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

### **4. TERMS UNDER WHICH THE CONTRACT MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

**RENEWABILITY: THIS CONTRACT IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your contract, to continue this contract as long as you pay your premiums on time. Thrivent Financial for Lutherans cannot change any of the terms of your contract on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

## **WAIVER OF PREMIUM BENEFIT.**

We will waive any premiums that come due while you incur expenses for Qualified Long-Term Care Services for which long-term care benefits are payable. When such expenses are no longer incurred, premiums will cease to be waived and you must resume paying premiums in order to keep your contract in force. Expenses eligible for Ancillary Benefits will not trigger Waiver of Premiums.

## **5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**

**After your contract has been in force for five years, we may change the premium for the contract but not more frequently than once a year. Any change will apply to all contracts issued in your state on this contract form. We will not change the premium due to changes in your health or due to any claims on your contract.**

## **6. TERMS UNDER WHICH THE CONTRACT MAY BE RETURNED AND PREMIUM REFUNDED.**

**30-Day Right to Cancel:** Within the first 30 days of receiving your contract, you may cancel it for any reason. The contract will be deemed void from the beginning and we will refund any premium paid within 30 days after we receive notice of cancellation and the returned contract.

### **Unearned Premium Refunds:**

If you cancel your contract after 30 days of first receiving it, the portion of any premium paid beyond the date of cancellation will be refunded. If your contract terminates due to your death or because your Available Benefit has been reduced to zero, the portion of any premium paid beyond the date of termination will be refunded.

## **7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Thrivent Financial for Lutherans, nor its agents represent Medicare, the federal government, or any state government.

## **8. LONG-TERM CARE COVERAGE.**

Contracts of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This contract provides coverage in the form of reimbursement for expenses that you incur for Qualified Long-Term Care Services when Eligibility for Benefits is met. Payment is subject to the Elimination Period, Maximum Monthly Benefit, Available Benefit, Exceptions and Limitations and all other terms and conditions of the contract.

**9. BENEFITS PROVIDED BY THIS CONTRACT.**

**a) Contract Benefit Limits:**

A. Maximum Monthly Benefit: \$ \_\_\_\_\_ (enter amount)

B. Benefit Multiplier:  24 months  36 months  60 months  96 months  120 months

C. Available Benefit (A. x B. = C.): \$ \_\_\_\_\_ (enter amount)

Elimination Period:  30 days  90 days  180 days

Increase Benefit Riders:  Compound 3%  Compound 5%  Flexible 5%

Cash Benefit Rider

Nonforfeiture Benefit Rider

Restoration of Benefits Rider

Return of Premium upon Death Rider

Shared Care Rider

Survivorship Rider

Waiver of Elimination Period for Home Care and Adult Day Care Rider

**b) Institutional Benefits:**

**Residential Care Facility Benefit.**

Residential Care Facility Benefit pays for Qualified Long-Term Care Services while you are confined in a nursing home, assisted living facility or hospice.

**Bed Reservation Feature.**

Bed Reservation Feature provides that the Residential Care Facility Benefit will not be interrupted by a temporary absence from the facility where you are a resident.

**c) Non-Institutional Benefits:**

Your contract includes benefits for Qualified Long-Term Care Services that are provided in an Adult Day Care Facility or in your home as Home Care Services.

**Adult Day Care Benefit.**

Adult Day Care Benefit provides social and health-related Qualified Long-Term Care Services in a community group setting to Chronically Ill people.

**Home Care Services.**

Home Care Services are Qualified Long-Term Care Services that are necessary to enable you to continue to live safely in your home. Home Care Services include homemaker services, home health aide services, skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional and dietary services and hospice care services.

**The contract also includes the following benefits:**

**Alternate Care Benefit.**

If your Plan of Care prescribes Qualified Long-Term Care Services that are not covered by the contract, we may pay benefits for such services if (1) the services are a cost-effective alternative to services covered by the contract and (2) you and we agree to a written alternate care benefit agreement.

**Ancillary Benefits.**

Ancillary Benefits are provided for Qualified Long-Term Care Services under Respite Care, Equipment/Home Modification, Caregiver Training and International Care. These benefits are not subject to the Elimination Period or the Maximum Monthly Benefit. Each benefit is subject to its own separate benefit limit and the Available Benefit.

- **Respite Care.**

Respite Care is designed to relieve an informal caregiver on a short-term basis and is provided in a residential care facility, adult day care facility, or a person's home as Home Care Services.

- **Equipment/Home Modification.**

Equipment/Home Modification provides coverage for special equipment such as a hospital bed, wheelchair, crutches or walker or safety-related equipment such as a medical alert system or any other medical equipment as specified in your Plan of Care.

Home modifications are accessibility changes such as a ramp, chair-lift or alterations to accommodate a wheelchair or safety-related changes such as installation of grab bars or railings or other changes to your home that are specified in your Plan of Care.

- **Caregiver Training.**

Caregiver Training means training that is (1) specified in your Plan of Care and (2) provided to your informal caregiver by a person who is licensed, certified or otherwise qualified to provide the training.

- **International Care.**

International Care provides limited coverage for Qualified Long-Term Care Services received outside of the United States.

**d) Eligibility for the Payment of Benefits:**

Your contract covers only Qualified Long-Term Care Services.

**Qualified Long-Term Care Services** are necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services and maintenance or personal care services that are:

- Required by a Chronically Ill individual; and
- Provided pursuant to a Plan of Care.

To be eligible for benefits under this contract, all of the following **Conditions on Eligibility for Benefits** must be met:

- You are Chronically Ill and receive Qualified Long-Term Care Services specified in a Plan of Care;
- The Elimination Period has been met, when applicable; and
- Coverage is not excluded.

**Chronically Ill** means that a licensed health care practitioner has within the preceding 12-month period certified in writing that you have:

- A **Physical Impairment** that is expected to last at least 90 days. A Physical Impairment prevents you from performing two or more of the following Activities of Daily Living without substantial assistance from another person: bathing, continence, dressing, eating, transferring or using the toilet; or
- A **Cognitive Impairment** which is an impairment of the mind that:
  - a) Is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia;
  - b) Is measured by clinical evidence and standardized tests that reliably measure impairment in an insured's short-term or long-term memory, orientation as to person, place or time, deductive or abstract reasoning, and judgment as to safety awareness; and
  - c) Results in the need for continual supervision (which may include cuing by verbal prompting, gestures or other demonstrations) by another person to protect that insured from threats to his or her health or safety (such as may result from wandering).

A **Plan of Care** is a written document that prescribes Qualified Long-Term Care Services that are consistent with an assessment of your impairment. The Plan of Care must be prepared and signed by a licensed health care practitioner and must include services or treatment that could not be omitted without adversely affecting your health.

#### **Care Coordinator Services.**

A care coordinator can help develop your Plan of Care. Care Coordinator Services are offered to assist in identifying care needs and community resources available to deliver care while you are Chronically Ill. If you contact us and use a care coordinator referred to you by us, these services are provided at no cost to you and are not subject to the Elimination Period.

#### **Contingent Nonforfeiture Benefit.**

Your contract includes a Contingent Nonforfeiture Benefit provision. This benefit provides you the option to reduce your coverage or convert to a reduced paid-up contract in the event of a substantial premium increase.

The paid-up coverage will have an Available Benefit equal to the lesser of the Nonforfeiture Credit and the Available Benefit in effect immediately before the date paid-up coverage becomes effective. The Nonforfeiture Credit is equal to the greater of the total of all premiums paid by you and applied to your contract and the Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective.

Benefits will be paid subject to all of the conditions and limitations of your contract. All optional benefit riders on your contract will terminate on the date paid-up coverage becomes effective. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

**e) Optional Benefits.**

For an additional cost, you may elect any of the optional benefit riders listed below.

**Nonforfeiture Benefit.**

After your contract has been in force for three years, the Nonforfeiture Benefit rider provides paid-up coverage if you give us notice to cancel your contract or your contract terminates for nonpayment of premium.

The paid-up coverage will have an Available Benefit equal to the lesser of the Nonforfeiture Credit and the Available Benefit in effect immediately before the date paid-up coverage becomes effective. The Nonforfeiture Credit is equal to the greater of the total of all premiums paid by you and applied to your contract and the Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective.

Benefits will be paid subject to all of the conditions and limitations of your contract. All optional benefit riders on your contract will terminate on the date paid-up coverage becomes effective. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

**Shared Care Benefit.**

The Shared Care Benefit rider allows you and your benefit partner to share each other's Available Benefit if one of you exhausts his or her own Available Benefit. You and your benefit partner must each own a Thrivent Financial for Lutherans long-term care insurance contract with identical coverage issued on the same date that includes this rider and names each other as a benefit partner.

**Survivorship Benefit.**

The Survivorship Benefit rider will waive your premiums for life if after ten years from the date of issue of the rider your benefit partner dies. This benefit will not be paid if either you or your benefit partner was Chronically Ill within the first ten years from the date of issue of the contract. You and your benefit partner must each own a Thrivent Financial for Lutherans long-term care insurance contract with the same date of issue that includes this rider and names each other as a benefit partner.

**Waiver of Elimination Period for Home Care and Adult Day Care.**

The Waiver of Elimination Period for Home Care and Adult Day Care rider will waive the Elimination Period requirement when receiving benefits for Home Care or Adult Day Care. The days of care you receive will still help you satisfy the Elimination Period for other types of care that may be needed in the future.

**Return of Premium upon Death.**

The Return of Premium upon Death rider will return premiums paid (less any benefits paid and accumulated dividends paid upon death) to your estate if you die and your rider has been in force for at least ten years. Benefits paid under this rider will reduce your Available Benefit. This benefit may have tax implications for your estate. You are advised to consult a tax advisor.

**Cash Benefit.**

In any calendar month in which you receive Long-Term Care Benefits for expenses incurred on at least five separate days and your Elimination Period has ended, the Cash Benefit rider pays you a benefit equal to:

- 15% of your Maximum Monthly Benefit in effect on the last day of the calendar month if on any of those days you receive Adult Day Care or Home Care Benefits; otherwise
- 10% of your Maximum Monthly Benefit in effect on the last day of the calendar month.

Benefits paid under this rider will not reduce your Available Benefit. This rider may have tax implications. You are advised to consult a tax advisor.

**Restoration of Benefits.**

The Restoration of Benefits rider restores your Available Benefit and amounts available for Ancillary Benefits if, after receiving benefits, you have not been Chronically Ill for a period of 180 consecutive days and your contract is still in force at the end of that period. The Available Benefit will be restored to the amount that would have been in effect had no benefits been paid. Amounts paid for Ancillary Long-Term Care Benefits prior to the day after the 180-day period will be disregarded when calculating new amounts payable for Ancillary Long-Term Care Benefits. There is no limit on how often benefits paid under your contract can be restored.

**10. LIMITATIONS AND EXCLUSIONS.**

- a) **Pre-existing Conditions Coverage:** Your contract does not exclude pre-existing conditions.
- b) **Non-eligible Facilities/Providers:** Your contract does not cover services provided by a facility or agency that does not meet the contract definition for such facility or agency, except as provided under the Alternate Care Benefit. This contract does not cover services provided in a clinic, hospital, sanatorium, or a home or facility for the treatment of mental illness, alcoholism or drug addiction.
- c) **Non-eligible Levels of Care:** Your contract does not cover services that are not Qualified Long-Term Care Services as defined in the contract.
- d) **Exclusions/Exceptions and Limitations:** Your contract does not pay benefits for:
  - Charges billed by a doctor;
  - Charges for prescription drugs;
  - Services outside the United States, its territories and possessions except under the International Care Benefit;
  - Services provided due to an attempt at suicide, while sane or insane, or an intentionally self-inflicted injury;
  - Services provided for the treatment of alcoholism or drug addiction.
  - Care or services provided by an immediate family member.
  - Which benefits are payable under any state or federal workers' compensation, employer's liability or occupational disease law;
  - Expenses which are reimbursable under Medicare or would be reimbursable under Medicare but for the application of a deductible or coinsurance amount;
  - Expenses that are paid under any other contracts or riders issued by us.

**THIS CONTRACT MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.**

**11. RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the cost of long-term care services will likely increase over time, you should consider whether and how the benefits under this contract may be adjusted. For this purpose, you may add an Annual Increase Benefit rider or a Flexible Increase Benefit rider for an additional cost.

An optional **Compound Annual Increase Benefit rider** increases your Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by either 5% or 3% (depending on which rider you select) of the corresponding amounts in effect immediately before the increase. Premiums for this rider are set at the time of issue. Increases in coverage under this rider will not cause an increase in your contract's premium.

An optional **Flexible Increase Benefit rider** increases your Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by 5% of the corresponding amounts in effect immediately before the increase. You may decline the increase. If you decline three consecutive increases, automatic annual increases will cease and future increases will be provided only on rider anniversaries occurring while premiums are being waived under the Waiver of Premium provision of the contract. Premiums for this rider are set at the time of issue. Your contract's premium will increase with each option elected and will be based on your age at the time of the increase.

At the end of this outline is a graphic comparison of the benefit levels of a contract that includes the increase benefit over the coverage period with a contract that does not include the increase benefit. A relative cost comparison chart illustrates long-term care contract premiums with and without the increase benefit.

**12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**

This contract includes benefits for persons who are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses and meet the qualifying for benefits requirements described in the contract.

**13. PREMIUM.**

The total annual premium for your contract including the optional benefits is listed below.

Base Contract	\$ _____
Cash Benefit Rider	\$ _____
Compound Annual Increase Benefit Rider (5% or 3%)	\$ _____
Flexible Increase Benefit Rider	\$ _____
Nonforfeiture Benefit Rider	\$ _____
Restoration of Benefits Rider	\$ _____
Return of Premium upon Death Rider	\$ _____
Shared Care Rider	\$ _____
Survivorship Rider	\$ _____
Waiver of Elimination Period for Home Care and Adult Day Care Rider	\$ _____

Total Annual Premium \$ \_\_\_\_\_

Your premium will be \_\_\_\_\_ on a \_\_\_\_\_ basis.

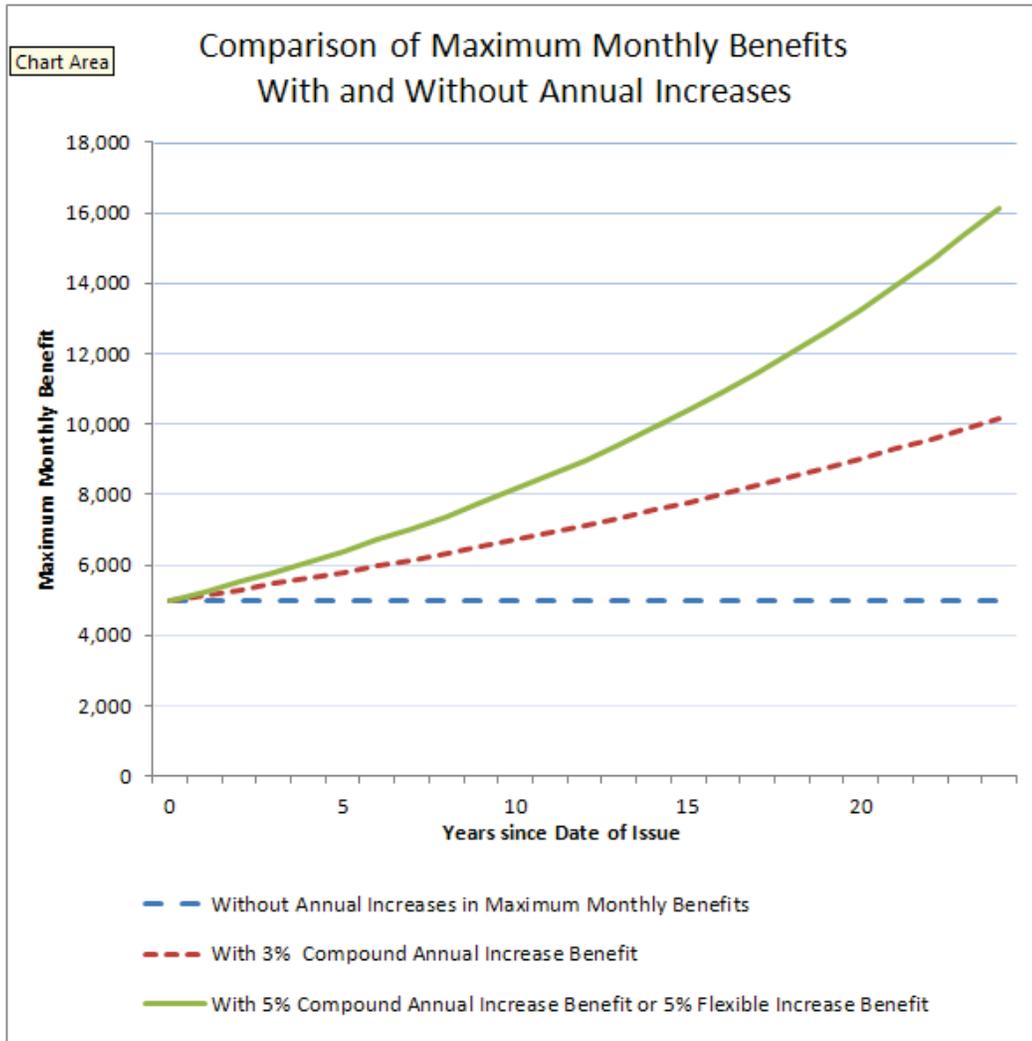
**14. ADDITIONAL FEATURES.**

The issuance of the contract is subject to medical underwriting.

**Unintentional Lapse.** You may designate at least one person other than yourself to receive notice of termination for nonpayment of premium. After a premium remains in default for 30 days, we will give this notice to you and any persons whom you have designated to receive such notice.

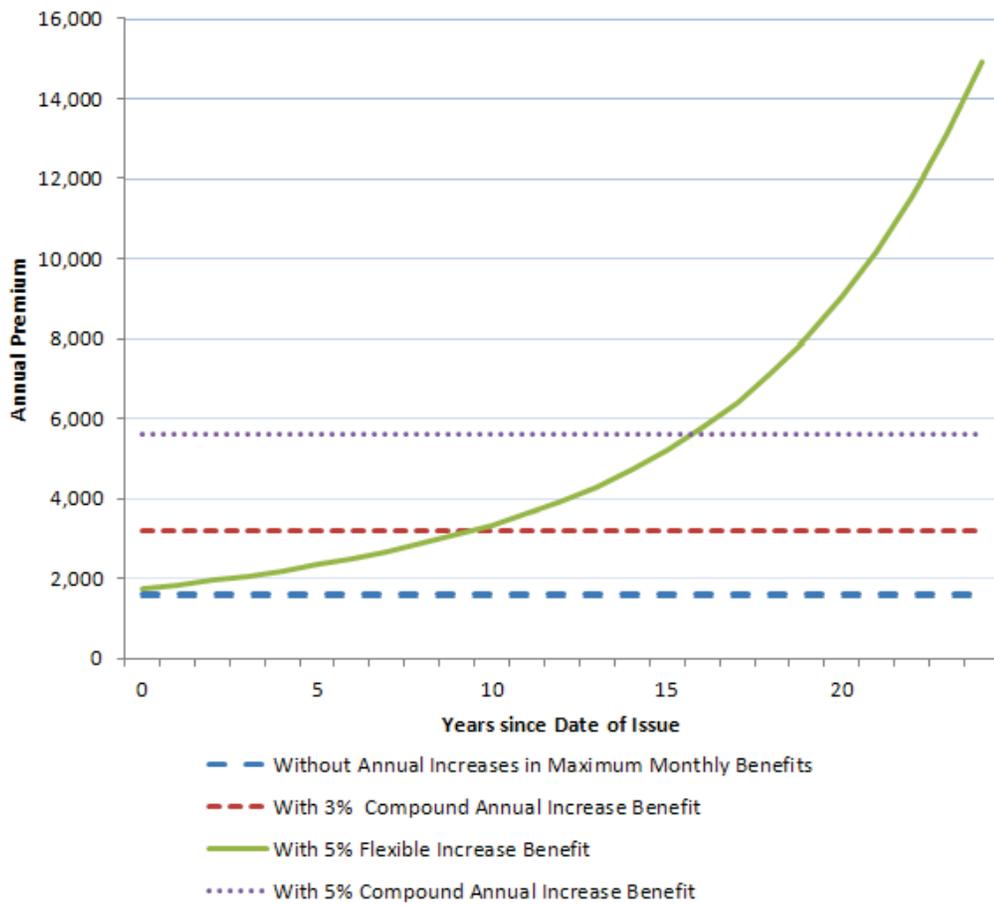
**15. CONTACT THE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE CONTRACT.**

**Comparisons of Maximum Monthly Benefits with and without the Annual Increases (Graph 1) and Comparison of Annual Premiums for Different Annual Increase Options (Graph 2)**



This data is shown for a 55 year old with a \$5,000 Maximum Monthly Benefit and Benefit Multiplier of 5 years. There is a 90 day Elimination Period and premiums are made annually for the life of the insured. There are no marital or underwriting discounts applied and no additional riders selected. For the Flexible Increase Benefit this assumes no increases are declined by the insured.

### Comparison of Annual Premiums for Different Annual Increase Options



## Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

### Premium Information

Policy form numbers  <b>H-HL-LTC (12)</b>	The premium for the coverage you are considering will be \$ _____ per month, or \$ _____ semiannually or \$ _____ per quarter, or \$ _____ year.	<b>Type of policy</b> (noncancellable/guaranteed renewable)  <b>Guaranteed Renewable</b>
---	--	---

### The Company's Right to Increase Premiums:

The company has a right to increase the premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

### Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy since 2012.

The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.

Thrivent Policy Series <sup>1</sup>	Years Available for Sale	Calendar Year of Increase	Percentages of Increase <sup>3</sup>
12105, 12106	1997-2003	2004 <sup>2</sup>	Range: 0% to 39% Average = 20%
H2-LN-LTC-1, H2-LH-LTCH-1	1990-1992	2004 <sup>2</sup>	Range: -19% to 59% Average = 13%
H2-LA-LTC-1	1992-1997	2004 <sup>2</sup>	Range: -22% to 59% Average = 16%
H3-NN-LTCN-1(97), H3-NC-LTCC-1(97)	1997-2003	2004 <sup>2</sup>	Range: 0% to 59% Average = 37%

<sup>1</sup> Not every policy series was available in every state.

<sup>2</sup> The increase was implemented over the years 2004 to 2009 as the filing process was completed for each state.

<sup>3</sup> Percentage of increase varies by state, issue age and plan of insurance.

### Questions Related to Your Income

How will you pay each year's premium?

From my Income     
  From my Savings/Investments     
  My Family will Pay

Yes     No   
 Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

---

What is your annual income? (check one)

- Under \$10,000       \$30,000-\$49,999       \$160,000-\$299,999  
 \$10,000-\$19,999       \$50,000-\$99,999       \$300,000-\$499,999  
 \$20,000-\$29,999       \$100,000-\$159,999       \$500,000 or over
- 

How do you expect your income to change over the next 10 years? (check one)

- No change       Increase       Decrease
- 

Explain if increase or decrease is expected

---

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

**Will you buy inflation protection?** (check one)     Yes     No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount?

- From my Income     From my Savings/Investments     My Family will Pay

The national average annual cost of care in 2010 was \$83,850 but this figure varies across the country. In 10 years the national average annual cost would be about \$136,675 if costs increase 5% annually.

---

What elimination period are you considering?

Number of days \_\_\_\_ .    Approximate cost \$ \_\_\_\_\_ for that period for care.

---

How are you planning to pay for your care during the elimination period?

- From my income       From my savings/investments       My family will pay
- 

### **Questions Related to Your Savings and Investments**

---

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

- Under \$20,000       \$20,000-\$29,999       \$30,000-\$49,999       \$50,000 or over
- 

How do you expect your assets to change over the next 10 years? (check one)

- Stay about the same       Increase       Decrease
- 

Explain if increase or decrease is expected

---

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

---

### **Disclosure Statement**

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**Check one.**

- The answers to the questions above describe my financial situation.

**Or**

- I choose not to complete this information.

**This box must be checked.**

- I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**
-

---

**Signatures**

---

Signature of applicant and date signed (mm/dd/yyyy)

---

Print name of applicant

---

I explained to the applicant the importance of completing this information.

---

Signature of agent and date signed (mm/dd/yyyy)

---

Print name of agent

---

In order for us to process your application, please return this signed statement to Thrivent Financial for Lutherans, along with your application.

My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

---

Signature of applicant and date signed (mm/dd/yyyy)

---

Signature of applicant and date signed (mm/dd/yyyy)

---

The company may contact you to verify your answers.

## THRIVENT FINANCIAL FOR LUTHERANS

### STATEMENT OF VARIABILITY

#### Long-Term Care Insurance Contract, Form H-HL-LTC (12)

The following items have been bracketed to indicate that the information may be different in different contracts or may be subject to change.

#### Items on Face Page of Contract

1. Service Center **address** and **telephone number** may be changed.
2. **Officers' signatures** will change if new officers are elected.
3. **INSURED, AGE, SEX, and CONTRACT NUMBER** are specific to each insured.
4. **DATE OF ISSUE** is the approval date.

#### Items on Page 3 of Contract

5. **Annual Premium** for Long-Term Care Insurance is based on insured's age, premium payment period, rate class, elimination period, maximum monthly benefit, benefit multiplier, and any applicable spousal discount.
6. **Premium Payment Period:** Lifetime or 10 years - 47 years
7. **Rate Class:**
  - Preferred
  - Preferred, 15% Couples Discount
  - Preferred, 35% Couples Discount
  - Standard
  - Standard, 15% Couples Discount
  - Standard, 35% Couples Discount
  - Substandard 1
  - Substandard 1, 15% Couples Discount
  - Substandard 1, 35% Couples Discount
  - Substandard 2
  - Substandard 2, 15% Couples Discount
  - Substandard 2, 35% Couples Discount
8. **Elimination Period:**
  - 30, 90 or 180
  - 30 or 90 (for Connecticut issues)
9. **Maximum Monthly Benefit:**
  - \$1,500.00 - \$15,000.00
  - \$3,000.00 - \$15,000.00 (for South Dakota issues)
10. **Benefit Multiplier:** 24, 36, 60, 96 or 120
11. **Available Benefit:** Maximum Monthly Benefit times the Benefit Multiplier
12. **Benefit Partner: Jane Doe**

This wording will only appear when there is a benefit partner. The name of the benefit partner is specific to each contract.
13. **Ancillary Benefit Limits\***
  - for Respite Care:** 2 times the Maximum Monthly Benefit

**for Equipment/Home Modification:** 2 times the Maximum Monthly Benefit

**for Caregiver Training:** 2 times the Maximum Monthly Benefit

**for International Care:** 2 times the Maximum Monthly Benefit

**14. Additional Benefits**

**The following Additional Benefit Riders are included:**

This wording will only appear when one or more riders are elected. For each rider elected, the name of the rider along with the rider premium, if any, will appear. The rider names are listed below:

**Cash Benefit**

**Compound 5% Annual Increase Benefit**

**Compound 3% Annual Increase Benefit**

**Flexible Increase Benefit**

**Limited Premium Payment Period Contingent Nonforfeiture Benefit**

**Nonforfeiture Benefit**

**Restoration of Benefits**

**Return of Premium upon Death**

**Shared Care Benefit**

**Survivorship Benefit**

**Waiver of Elimination Period for Home Care and Adult Day Care**

**15. Total Annual Premium**

The sum of the premium for Long-Term Care Insurance and the premiums for any Additional Benefit Rider(s).

**16. Interval of Payment**

Annual, Semiannual, Quarterly or Monthly

**17. Initial Premium**

The premium paid for the Interval of Payment selected.

**18. Telephone Number** of the insurance department of the state in which this contract was issued may change.

**19. INSURED, AGE, SEX, and CONTRACT NUMBER** are specific to each insured.

**20. DATE OF ISSUE** is the date the application is signed.

**Cash Benefit Rider, Form HR-HC-CB (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

**Compound 3% Annual Increase Benefit Rider, Form HR-HT-CAIB3 (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Compound 5% Annual Increase Benefit Rider, Form HR-HV-CAIB5 (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Flexible Increase Benefit Rider, Form HR-HF-FIB (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Limited Premium Payment Period Contingent Nonforfeiture Benefit Rider, Form HR-HL-LCNF (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Nonforfeiture Benefit Rider, Form HR-HN-NF (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Restoration of Benefits Rider, Form HR-HR-RB (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Return of Premium upon Death Rider, Form HR-HP-RP (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Shared Care Benefit Rider, Form HR-HS-SC (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Survivorship Benefit Rider, Form HR-HU-SU (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Waiver of Elimination Period for Home Care and Adult Day Care Rider, Form HR-HE-WEP (12)**

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Contract Number** and **Date of Issue of this Rider** are specific to each Insured.
2. **Officers' signatures** will change if new officers are elected.

### **Application for Individual Long-Term Care Insurance, Form 27154 N1-12**

The following items have been bracketed to indicate that the information may be different in different applications or may be subject to change:

1. **Contract Pay Type** - types may be deleted from the list in Section 3 on page 2 if they become no longer available.
2. **Frequency** types may be deleted from the list in Section 5 on page 3 if they become no longer available.

Any minor typographical errors that are discovered in these forms will be corrected.

**THRIVENT FINANCIAL FOR LUTHERANS**

**STATEMENT OF VARIABILITY**

**APPLICATION CHANGE, FORM 20887A N1-12**

The body of this form is bracketed to indicate that the language that will be printed will vary depending upon each individual situation. All variable text is listed below:

I am a citizen of the United States of America (USA).

I am not a citizen of the United States of America (USA).

I am a permanent resident of the USA.

I am not a permanent resident of the USA.

I am married or have a state-recognized partner.

I am single and do not have a state-recognized partner.

I am one of two individuals in a committed relationship who have been living together for at least three consecutive years as partners or family members, and are committed to sharing expenses, and if related, belong to the same generation.

I am not one of two individuals in a committed relationship who have been living together for at least three consecutive years as partners or family members, and are committed to sharing expenses, and if related, belong to the same generation.

My spouse/partner/family member is applying for the long-term care insurance rider with Thrivent Financial and my spouse/partner/family member name is <insert name>.

My spouse/partner/family member is not applying for the long-term care insurance rider with Thrivent Financial.

My spouse/partner/family member does have a long-term care or nursing home contract with Thrivent Financial and the contract number is <insert number>.

My spouse/partner/family member does not have a long-term care or nursing home contract with Thrivent Financial.

I am not covered by a state assistance program (e.g. Medicaid).

I currently do have another long-term care insurance policy or contract in force (including health care service contract, health maintenance organization contract).

I currently do not have another long-term care insurance policy or contract in force (including health care service contract, health maintenance organization contract).

I do have life insurance or annuity contracts currently in force which provide similar long-term care coverage.

I do not have life insurance or annuity contracts currently in force which provide similar long-term care coverage.

The following question regarding replacement and other coverage should be answered 'Yes': Will coverage be discontinued if this long-term care insurance contract is issued?

The following question regarding replacement and other coverage should be answered 'No': Will coverage be discontinued if this long-term care insurance contract is issued?

The following question regarding replacement and other coverage should be answered 'Yes': Did you have another long-term care, nursing home policy, contract in force during the last 12 months that is no longer in force?

The following question regarding replacement and other coverage should be answered 'No': Did you have another long-term care, nursing home policy, contract in force during the last 12 months that is no longer in force?

The benefit multiplier has been changed to: 24 months

The benefit multiplier has been changed to: 36 months

The benefit multiplier has been changed to: 60 months

The benefit multiplier has been changed to: 96 months

The benefit multiplier has been changed to: 120 months

The elimination period has been changed to: 30 day

The elimination period has been changed to: 90 day

The elimination period has been changed to: 180 day

The maximum monthly benefit amount has been changed to: \$<insert amount>

The contract pay type has been changed to Lifetime Pay.

The contract pay type has been changed to 10-Pay.

The contract pay type has been changed to Pay to Age 65.

The benefit increase option has been changed to: AIB 3% Compound

The benefit increase option has been changed to: AIB 5% Compound

The benefit increase option has been changed to: Flexible Increase Benefit

The benefit increase option has been changed to: None

I have reviewed the outline of coverage and the graphs that compare the benefit and premiums of this contract with and without annual increase benefit, and I reject annual increase benefit.

The following optional rider has been added to your contract: Cash Benefit

The following optional rider has been added to your contract: Nonforfeiture Option

The following optional rider has been added to your contract: Restoration of Benefits

The following optional rider has been added to your contract: Return of Premium upon Death

The following optional rider has been added to your contract: Shared Care

The following optional rider has been added to your contract: Survivorship Benefit

The following optional rider has been added to your contract: Waiver of Elimination Period for Home Care and Adult Day Care

The following optional rider has been deleted from your contract: Cash Benefit

The following optional rider has been deleted from your contract: Nonforfeiture Option

The following optional rider has been deleted from your contract: Restoration of Benefits

The following optional rider has been deleted from your contract: Return of Premium upon Death

The following optional rider has been deleted from your contract: Shared Care

The following optional rider has been deleted from your contract: Survivorship Benefit

The following optional rider has been deleted from your contract: Waiver of Elimination Period for Home Care and Adult Day Care Rider

The date I signed the application for long-term care insurance is <insert date>.

The legal name of the insured is indicated on the page 3 of the contract.

The application was signed in <insert city, state>.

The contract change has been completed on contract number <insert number>.

Answer to question 1 in Section 2 on the Preliminary Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 2 in Section 2 on the Preliminary Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 3 in Section 2 on the Preliminary Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 4 in Section 2 on the Preliminary Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 5 in Section 2 on the Preliminary Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 6 in Section 2 on the Preliminary Declaration of Insurability Long-Term Care Insurance is no.

On the Declaration of Insurability Long-Term Care Insurance the correct height and weight is <insert height and weight>.

Answer to question 1a in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1a in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1b in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1b in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1c in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1c in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1d in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1d in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1e in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1e in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1f in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1f in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1g in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1g in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1h in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1h in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1i in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1i in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 1j in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 1j in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 2 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 3 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 4a in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 4a in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 4b in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 4b in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 4c in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 4c in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 4d in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 4d in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 5 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 5 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 6 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 6 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 7 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 7 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 8 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 8 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 9 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 9 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 10 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 10 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 11 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 11 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 12 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 12 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 13 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is <insert correct information on occupation status>.

Answer to question 14 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is <insert correct information on type of dwelling>.

Answer to question 15 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 15 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

Answer to question 16 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is no.

Answer to question 16 in Section 2 on the Declaration of Insurability Long-Term Care Insurance is yes.

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, e.g., as it introduces new long-term care insurance policy forms for issuance.

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**I. GENERAL INFORMATION**

**A. Name, address and telephone number of issuer:**

THRIVENT FINANCIAL FOR LUTHERANS  
625 FOURTH AVE S. MPLS MN 55415  
800-847-4836

**B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:**

MATT HOLDERNESSE, 625 Fourth Ave S. MPLS MN 55415  
800-847-4836 Ext 35107  
matt.holderness@thrivent.com

**C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):**

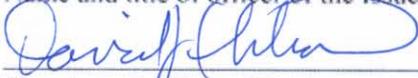
Policy Form H-HL-LTC(12)

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

**II. CERTIFICATIONS**

- A. I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.
- B. I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on {insert issuer name's} behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.
- C. I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

8/06/2012  
Date

David J. Christianson, Director  
Name and title of officer of the Issuer  
  
Signature of officer of the Issuer